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In this issue

**Update on Irish
prison data**
See page 19

09 Planet Youth: data from
Western region

11 Hidden harm

14 BME communities

23 Restorative justice

25 Educational disadvantage

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Government announces new Health Diversion Approach to drug possession for personal use

On 2 August 2019, the Government announced the launch of a Health Diversion Approach to the possession of drugs for personal use. The final report of the Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use and supporting documents were also published that day.^{1,2,3} Taking into consideration the findings of this report and the range of stakeholder views, the Department of Health and the Department of Justice and Equality agreed to adopt a more health-led approach to possession for personal use.



Minister for Health, Simon Harris TD, Minister of State for Health Promotion and the National Drugs Strategy, Catherine Byrne TD, and Minister for Justice and Equality, Charlie Flanagan TD, at the announcement of the new Health Diversion Approach to the possession of drugs for personal use in August

Contents

COVER STORY

| | |
|----------------------------------------------------------------------------------------|----|
| Government announces new Health Diversion Approach to drug possession for personal use | 01 |
|----------------------------------------------------------------------------------------|----|

POLICY AND LEGISLATION

| | |
|-------------------------------------------------------------------------|----|
| Public Health (Alcohol) Act 2018 | 06 |
| What Works: Sharing Knowledge, Improving Children's Futures | 09 |
| Planet Youth in WRDATF | 09 |
| Progress report on national drugs strategy for 2018 | 11 |
| Hidden Harm strategic statement | 11 |
| Headshop legislation and changes in drug-related psychiatric admissions | 13 |
| Meeting the needs of BME communities – organisational connector models | 14 |

PREVALENCE AND CURRENT SITUATION

| | |
|-----------------------------------------------------------------------------------------------------------|----|
| Has an increase in the dispensing of pregabalin influenced poisoning deaths in Ireland? | 15 |
| National Self-Harm Registry annual report, 2017 | 17 |
| Trends in addiction treatment in Irish prisons | 19 |
| Hepatitis C virus screening and treatment in Irish prisons from a governor and prison officer perspective | 20 |
| Deaths in custody in Irish prisons | 21 |
| Self-harm in Irish prisons | 22 |

RESPONSES

| | |
|-----------------------------------------------------------|----|
| Restorative justice – strategies for change | 23 |
| Addressing educational disadvantage – Youthreach and DEIS | 25 |
| Tabor Group annual report, 2018 | 28 |

UPDATES

| | |
|---------------------|----|
| Recent publications | 30 |
|---------------------|----|

The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website www.drugsandalcohol.ie

In brief

The theme of the National Drugs Forum for 2019 is 'Inclusion Health: responding to complex health needs of people who use drugs'. Inclusion health is an emergent approach to policy development, service delivery, and research. It seeks to explain the health impact for those living as part of a vulnerable and excluded population, and to work towards preventing and redressing the consequences of these determinants.

Health and social interventions based on an inclusion-health approach target people who are experiencing or have experienced homelessness, drug use, imprisonment, sex work, mental health difficulties, or other adverse life experiences that have led to social exclusion and marginalisation.

Interventions designed to improve physical and mental health must look beyond singular risk factors such as problematic drug use. They must respond to the multiple and complex needs of socially excluded populations who have common intersecting characteristics and adverse life experiences, such as childhood trauma and poverty.

A research programme based on inclusion health principles will increase awareness of the need for preventive and early intervention approaches, the consequences of extreme inequity, and the importance of structural interventions. These include housing, employment, and legal support in reducing exclusion and supporting recovery.

The National Drugs Forum was fortunate to hear from two speakers who have made important contributions to the concept of inclusion health and the practical implications of configuring our healthcare and other services to meet the needs of our most vulnerable populations. We can now build on this learning and ensure that inclusion health is a key strand in the synthesis of evidence and experience informing the development of effective interventions in Ireland.

Government announces new Health Diversion Approach

continued

The Health Diversion Approach offers alternatives to criminal prosecutions for the first **two** instances in which people are found in possession of drugs for their personal use. Essentially, the action taken by An Garda Síochána (AGS) will depend on the number of times an individual has been caught in possession.

- On the first occasion, AGS will refer them, on a mandatory basis, to the Health Service Executive (HSE) for a health screening and brief intervention.
- On the second occasion, AGS will have the discretion to issue an adult caution.
- On the third or any subsequent occasion, AGS will revert to dealing with the person in line with Section 3 of the Misuse of Drugs Act 1977, under which they could receive a criminal conviction and custodial sentence.

The health screening and brief intervention will be carried out by trained HSE staff using the Screening and Brief Intervention for Problem Alcohol and Substance Use (SAOR) programme. New posts will be created across the HSE's Community Healthcare Organisation Areas for staff trained in SAOR to carry out the brief intervention. By November 2019, no further details were available on how the new approach will be implemented.

An implementation, monitoring, and evaluation group has been established to examine the need for legislative change, the operational details, and the phasing of the implementation. The group will be chaired by the Department of Health and its membership will include, but not be limited to, the HSE, AGS, and the Department of Justice and Equality. It is expected that this group will begin its work in Q4 2019, with the aim of phasing in the Health Diversion Approach in Q3 2020.

Other recommendations made by the Working Group, but which were not considered by Government, included that imprisonment would no longer be an outcome for the possession of drugs for personal use and that all related convictions could be spent.⁴

This issue of *Drugnet Ireland* looks at three other topics related to the new approach:

- 1 An overview of the final report of the Working Group, focusing on its recommendations.
- 2 A more detailed overview of the Working Group's conclusions on the question of decriminalisation in the Irish context.
- 3 Stakeholder responses to the Working Group's report and the Health Diversion Approach

1. Overview of Working Group's final report

In December 2017, the Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use was established. It was set up to deliver on a commitment in Ireland's national drugs strategy to 'consider the approaches taken in other jurisdictions to the possession of small quantities of drugs for personal use with a view to making recommendations on policy options to the relevant Minister within 12 months' (p. 58).⁵ The group undertook a programme of research and consultation to identify alternatives to the current system and to consider which alternatives would be

appropriate in the Irish context.^{2,3} The group's final report was published on 2 August 2019.¹

Report overview

The report presents an overview of the current situation in Ireland in relation to the possession of drugs for personal use. It maps out Ireland's current legislative regime and the rationale underpinning it as well as the current options available to the courts when prosecuting for simple possession. The report includes key findings from research commissioned by the Working Group on the legislative approach taken in Ireland compared with other jurisdictions, and outlines a set of possible options that could work in the Irish context. There is also an overview of the public consultation and various stakeholder presentations made in the course of the group's work. Key findings from an examination of the costings of alternative approaches carried out by the Irish Government Economic and Evaluation Service (IGEES) in the Department of Justice are also included.³ The report outlines the Working Group's considerations on a selection of policy approaches and their suitability to the Irish context.

Principles

In considering different policy approaches and making their recommendations, the Working Group identifies three principles that alternatives should address, while also being cognisant of potential difficulties imposed by Ireland's legal system:

- A person should be afforded the opportunity to avoid a criminal conviction for the possession of drugs for their personal use
- A person should be supported to avoid, reduce and recover from drug-related harm
- A person with problematic drug use should be referred to appropriate treatment or other support (p. 58).¹

Recommendations

In the final chapter of the report, the Working Group presents a set of recommendations. These are based on detailed discussion of the evidence gathered in the course of its work, its consultations and its discussions of the various alternatives. It recommends three policy options for the legislature to consider. It regards these as both workable in the Irish context and can address the concerns of Government and the public, albeit to varying degrees.

Option 1: Adult caution

- The Adult Cautioning Scheme is a discretionary alternative to prosecution, whereby a person found in possession of drugs for personal use could be given a formal caution by Gardaí, who could also provide the individual with a health and social services information leaflet.

Option 2: Multiple adult cautions

- Subject to the agreement of the Director of Public Prosecutions, a person could be given the benefit of an adult caution by Gardaí more than once. This could provide a discretionary alternative to prosecution and criminal conviction on more than one occasion.
- The individual would also be provided with a health and social services information leaflet, whenever they are given an adult caution in respect of possession of drugs for personal use.

Option 3: Diversion to health services

- This option is based on a public health approach to drug use.

Government announces new Health Diversion Approach

continued

- A person in possession of drugs for personal use would be offered a diversion for a SAOR brief intervention and screening.
- A person with or at risk of problematic drug use would then be offered the appropriate onward referral for treatment or other supports.

In addition to these three policy options, the Working Group makes a set of other recommendations:

- That imprisonment, in principle, is no longer an outcome for the possession of drugs for personal use (subject to a full examination of the legal implications and any unforeseen consequences).
- That all convictions for drug possession for personal use can be spent.⁶ In addition, that the time between the conviction and it becoming spent be reduced from seven years to three years.
- That a dismissal or non-conviction under the Probation Act is recorded correctly so that it will be clear when the person's records are being checked.
- That current legislation is not changed to include a threshold limit to distinguish between what is meant by personal use versus that for sale or supply.
- Given the nature of problem substance use as a chronic, often recurring condition, that there are pathways available at all levels of the criminal justice system to refer people to treatment following prosecution.
- That additional investment in services is made to meet the greater treatment demand that may come from any change in related policy.
- That there is a campaign to increase awareness of the treatments available and the harms associated with drug use. It mentions in particular those associated with cannabis use.
- That any alternative approach introduced in Ireland is monitored, has a data collection mechanism, an evaluation of the implementation, and scope for appropriate modification.

2. Working Group's conclusions on decriminalisation in Irish context

The Working Group considered decriminalisation as one of the alternative policy approaches to dealing with possession for personal use in the Irish context. It was ultimately rejected by the Working Group and not considered by the Government when developing their Health Diversion Approach.

Portuguese approach

Decriminalisation has received a lot of attention among stakeholders over recent years and throughout the lifetime of the Working Group, in particular 'the Portuguese approach' (p. 61).¹ As defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), under decriminalisation 'the status of the offence is reclassified from a criminal offence to a non-criminal offence within a country's legal framework. It is still an offence, it is still prohibited behaviour that will be stopped by police and punished, but it is no longer considered criminal' (p. 27).¹ Research commissioned by the Working Group

described Portugal as using a model of 'decriminalisation with targeted diversion to health/social services' (p. 68).²

The Director of the National Unit to Combat Trafficking in Narcotic Drugs of Portugal's Judicial Police made a presentation to the Working Group. He described how in Portugal the possession of drugs for personal use continues to be illegal. However, the offence is not a criminal one but is considered to be a misdemeanour for which a penalty or sanction can be applied. When a police officer finds a person in possession, they refer the person to a 'drug dissuasion committee' – this is a local administrative body for drug addiction, set up by Portugal's Ministry for Health. The individual has a mandatory obligation to report to the committee on referral from a member of the police. There is no limit to the number of referrals an individual can get.

Suitability to Irish context

Having given 'considerable time over the course of its meetings to examining how a similar approach could be adopted in Ireland' (p. 61),¹ the Working Group concluded that decriminalisation along the lines of that in Portugal was not suited to the Irish context. The decision is based on their understanding that the Irish legal system is not compatible with decriminalisation. Unlike most European Union countries, Ireland is a common law jurisdiction, not a codified civil law jurisdiction. The Working Group argues that there would be difficulties in applying decriminalisation (as defined by the EMCDDA) – in particular, that the concept of a criminal offence with an administrative or civil sanction would not be compatible with the Irish legal system. Decriminalisation would require an amendment to Section 3 of the Misuse of Drugs Act 1977 so that possessing drugs for personal use would no longer be an offence. The Working Group identified three main problems with making such a legislative change:

- The Gardaí would no longer have the power to stop and search a person for possession of drugs for their personal use. The Working Group considered whether Garda powers to stop and search based on public health considerations could be preserved if possession for personal use was decriminalised, and formed the view that this could give rise to constitutional and legal difficulties as no criminal offence would have been committed.
- Organised crime gangs could use the limits set for personal possession to facilitate a supply chain just below these thresholds. Although the report also notes that the 'Working Group understands that people involved in the sale and supply of drugs already carry minimum amounts of drugs in order to avoid criminal prosecution for sale or supply at present in Ireland' (p. 61).¹
- Removal of the offence could lead to de facto legalisation 'given that there would no longer be a criminal offence of possession for personal use' (p. 67),¹ and there may be unintended and undesirable consequences.

Recommendations

Given this context, the Working Group did not recommend the Portuguese model of 'decriminalisation with targeted referral to services' as appropriate for the Irish context. Instead, it concluded that the best way to mirror such an approach would be to continue to have possession for personal use as an offence, so that Gardaí have the power to stop and search but that they would also be able to divert people to appropriate services (p. 67).¹ This rationale was cited by Minister for Health Simon Harris in his speech at the launch when explaining why

Government announces new Health Diversion Approach

continued

the Government decided not to decriminalise possession for personal use.⁷

3. Responses to Working Group's report and Government's Health Diversion Approach

The work and findings of the Working Group as well as the Government's new approach have attracted much interest among stakeholders. The views of stakeholders vary and reflect the debate about whether possession for personal use calls for a health- or justice-led response. Some responses to the report and the Government's approach are considered here.

Justice-led approach

The Working Group's report includes addenda containing the views of three stakeholders, from the field of justice, on the report's recommendations: namely, a representative of the Office of the Director of Public Prosecutions (ODPP), An Garda Síochána (AGS), and a Senior Lecturer in Law.¹ The report does not describe the process through which these responses were selected for inclusion. The responses included:

- The ODPP considers that the removal of a custodial penalty (recommendation (a) above) would also remove from the options of community service orders and suspended sentences from the courts.
- As a response to possession for personal use, AGS does not support the introduction of multiple adult cautions (option 2 above), the removal of a custodial penalty (recommendation (a) above), and has reservations about recommendation (b) that all such convictions could be spent.
- AGS criticises the report for not giving more consideration to the impact of the drugs market on organised crime in Ireland.
- AGS does not consider the Working Group to have fully explored the procedural and legal impediments to the alternative approaches and therefore does not recommend full adoption of the report's findings.
- AGS supports recommendations (c)–(h) as outlined above.

Similar views are expressed by the chairperson of the Working Group in his minority report.⁸

Health-led approach

The Government's decision to move towards a more health-led approach has been broadly welcomed by other stakeholders. However, there have been criticisms that the report's recommendations and the Government's approach have not gone far enough in the direction of health. Below are some of the views expressed in two stakeholder responses: an open letter to An Taoiseach signed by 52 civil society organisations (though sent prior to the launch of the report, it was based on 'indications' of what the report would contain, which reflected accurate content) and an opinion piece from the Ana Liffey Drug Project.^{9,10}

- The civil society representatives argue that implementing a health diversion approach while maintaining a criminal status for possession for personal use is 'contradictory and lacking in logic'.⁹

- The value of limiting a person to only one opportunity to be diverted to a health intervention is challenged. Ana Liffey contends that 'if drug use is a health issue the first time, it is a health issue the hundredth time'.¹⁰ It argues that this approach will further marginalise and stigmatise the most vulnerable users. Given the nature of their drug use and their circumstances, they are more likely to come into contact with AGS, and therefore will continue to be treated as criminals.
- Both responses challenge the assumptions that the 'legal changes required to decriminalise possession for personal use would be too complicated'⁹ and that decriminalisation could not be made compatible with retaining the powers of AGS to stop, search, and confiscate drugs. Both call for a more detailed consideration of how appropriate legislation could be developed.
- Ana Liffey view the proposed Health Diversion Approach as unnecessarily 'complicated and bureaucratic' and argue that it does not represent 'value to the taxpayer'.¹⁰
- The Government is criticised for not considering other recommendations of the Working Group. In particular, that imprisonment would no longer be an outcome for the possession of drugs for personal use and that all related convictions could be spent.⁶

Lucy Dillon

- 1 Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use (2019) *Report of the Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use*. Dublin: Department of Health and Department of Justice and Equality. <https://www.drugsandalcohol.ie/30887/>
- 2 Hughes C, Stevens A, Hulme S and Cassidy R (2019) *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences. A report for the Irish Department of Justice and Equality and the Department of Health*. Sydney and Canterbury: University of New South Wales and University of Kent. <https://www.drugsandalcohol.ie/30895/>
- 3 Irish Government Economic and Evaluation Service (2019) *Costings of an alternative approach to drug possession*. Dublin: Department of Justice and Equality. <https://www.drugsandalcohol.ie/30887/>
- 4 Department of Health (2019) Ministers Harris, Flanagan, and Byrne announce health-led approach to the possession of drugs for personal use. Press release, 2 August 2019. Dublin: Department of Health. <https://www.drugsandalcohol.ie/30888/>
- 5 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 6 Under the provisions of the Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016, an adult convicted of an offence covered by the Act does not have to disclose the conviction after seven years, except in certain circumstances.
- 7 Department of Health (2019) Speech by Minister Harris at launch of health diversion approach for drug use. 2 August 2019. Dublin: Department of Health. <https://www.drugsandalcohol.ie/31070/>
- 8 Sheehan G (2019) Minority report of Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use. Dublin: Department of Health and Department of Justice and Equality. <https://www.drugsandalcohol.ie/30887/>
- 9 CityWide Drugs Crisis Campaign (2019) An open letter to Taoiseach Leo Varadkar. 15 July 2019. Dublin: CityWide Drugs Crisis Campaign. <https://www.citywide.ie/resources/open-letter-to-taoiseach-july-2019/>
- 10 Keane M (2019) Opinion: The government's new drug policy will do nothing to end the stigmatisation of drug users. *Thejournal.ie*, 7 August 2019. <https://www.drugsandalcohol.ie/30897/>

POLICY AND LEGISLATION

Public Health (Alcohol) Act 2018

The Public Health (Alcohol) Act 2018¹ was signed into law by the President of Ireland on 17 October 2018. The Act faced much opposition from various interest groups and the three-year interval between publication of the Bill and enactment of the Act was the longest ever in Ireland. This Act is particularly significant because, for the first time in Ireland, alcohol is being treated as a public health issue. The aim of the Act is to reduce alcohol consumption in Ireland and the harms it causes at a population level. There is a particular emphasis on reducing harm to young people and children, who are most vulnerable to the negative consequences of alcohol consumption. The first restrictions on advertising recently became law on 12th November.

Table 1: Summary of provisions of the Public Health (Alcohol) Act 2018

| Measure | Rationale | Commenced |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Minimum unit pricing | | |
| <p>Minimum unit pricing (MUP) for all products containing alcohol will be introduced and set at 10 cent per gram of alcohol in the product. Unlike a tax increase where a retailer can choose to absorb the increase in price, MUP will be compulsory across all alcohol products. Under the new legislation:</p> <ul style="list-style-type: none"> A 750 ml bottle of wine with a strength of 12% will cost a minimum of €7.10. A 700 ml bottle of vodka with a strength of 35% will cost at least €20.71. A 500 ml can of beer with a strength of 5% will cost a minimum of €1.97. | <p>Research conducted by the Health Research Board and the Royal College of Surgeons in Ireland (RCSI) prior to the introduction of MUP indicated that the heaviest drinkers and those on lower incomes, such as students, buy the cheapest alcohol and are likely to be most affected by MUP.² Currently, it is possible for a man to reach his weekly recommended alcohol limit for €7.48, while a woman can reach hers for just €4.84.³ Increasing the price of alcohol products reduces its affordability and reportedly is one of the most effective ways of reducing alcohol consumption and related harm.⁴</p> | <p>MUP has yet to be commenced.</p> |
| Health warning labels | | |
| <p>Section 12 of the Act stipulates that all alcohol products to be sold in Ireland will be required to display:</p> <ul style="list-style-type: none"> A warning informing the public of the danger of alcohol consumption A warning outlining the danger of alcohol consumption when pregnant A warning informing the public of the direct link between alcohol and fatal cancers The quantity in grams of alcohol contained in the container concerned The calorie content in the container concerned Details of a website, to be established and maintained by the Health Service Executive, providing public health information in relation to alcohol consumption. | <p>Health warning labels ensure the public have accurate information regarding the calorie content and alcohol strength of alcohol products and that they are informed of the health risks associated with alcohol consumption. Research published in a previous issue of <i>Drugnet</i>⁵ demonstrates that current public knowledge of the link between cancer and alcohol in Ireland is low. Just one-quarter of Irish women are aware of the direct link between alcohol and breast cancer, despite being the most common type of cancer experienced by women in Ireland.</p> | <p>This provision has yet to be commenced. Health warning labels on alcohol products are subject to approval at European level</p> |
| Structural separation | | |
| <p>Section 22 of the Act provides for the structural separation of alcohol products in mixed retail outlets (e.g. supermarkets and grocery stores). Retailers must choose from one of three options:</p> <ol style="list-style-type: none"> Store alcohol in an area of the store that is separated by a physical barrier. Store alcohol products in one or more closed storage units or cabinets. Store alcohol products in no more than three open storage units in the premises. | <p>Limiting the physical availability of alcohol is an important population-based measure to reduce alcohol consumption. Interventions targeting the availability of alcohol at a population level have been found to be most effective in reducing alcohol-related harm and consumption.⁴</p> | <p>Structural separation was commenced on 12 November 2018. By 12 November 2020, all mixed-trade retailers will be obliged by law to physically separate alcohol products from other grocery items.</p> |

Public Health (Alcohol) Act 2018

continued

| Measure | Rationale | Commenced |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Advertising | | |
| <p>A range of restrictions will apply to the advertisement of alcohol products, with a particular emphasis on protecting children and young people. The main restrictions include:</p> <ul style="list-style-type: none"> • Content of advertisements will be restricted to specific information about the nature of the product. • Advertisements must contain health warnings regarding alcohol consumption, including during pregnancy, and a link to a public health website. • Advertisements in cinemas will be limited to films classified as over 18s. • There will be a 9 p.m. broadcast watershed for advertisements on television and radio. • The marketing and advertising of alcohol in the print media will be restricted in relation to volume and type of publication. <p>There will be a ban on advertising of alcohol products:</p> <ul style="list-style-type: none"> • In or near a school • In or near an early years service (e.g. early years crèche) • A park, open space or playground owned or maintained by a local authority • On public transport • In a train or bus station, and at a bus or Luas stop. <p>The Act will also restrict the sale of children's clothing which promotes alcohol consumption or bears alcohol brands/products.</p> | <p>Advertising has been related to initiation of alcohol consumption, especially among children and adolescents, who are particularly vulnerable to advertising and marketing campaigns.⁶ Reducing children and young people's exposure to alcohol advertising may delay initiation and reduce alcohol consumption among young people. Early initiation of alcohol use has been associated with a number of negative consequences for alcohol use, including increased likelihood of dependence later in life.⁷</p> | <p>Some of these measures have recently become law, including measures around advertising in the vicinity of children (Sections 14, 20 and 17). Important measures yet to be commenced are: Section 13 on the restriction of the content of alcohol advertisements; Section 18 regarding limitations of advertising in the print media; and Section 19 regarding the broadcast watershed on alcohol advertising.</p> |
| Sports sponsorship and sponsorship of other events aimed at children | | |
| <p>With the exception of motorsport, the Act does not ban alcohol sponsorship of sport. However, Section 15 of the Act prohibits advertising in sports grounds for events where the majority of competitors or participants are children or directly on a sports area for all events (e.g. on the actual pitch, the race track, tennis court, etc.). Alcohol sponsorship of other events aimed at children or where most of the participants are children will also be prohibited under Section 16.</p> | <p>As above, exposure to alcohol advertising and media has been associated with earlier initiation of drinking among adolescents and an increase in the volume of consumption among adolescents who already drink.⁶ Prohibiting advertising at events aimed at children will further limit exposure to alcohol advertising.</p> | <p>Both Section 15 and Section 16 were commenced in November 2018, with a three-year transition period.</p> |

Public Health (Alcohol) Act 2018

continued

| Measure | Rationale | Commenced |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Restrictions on the sale and supply of alcohol products | | |
| <p>Section 23 of the Act outlines a number of restrictions regarding the sale and availability of alcohol products. Several measures regarding limiting the sale and availability of alcohol products are outlined in the Act. One of the most important of these is the restriction of price-based promotions, to which young people may be particularly sensitive.</p> <p>Under Section 23, the Minister will have the power to make regulations around:</p> <ul style="list-style-type: none"> • The sale or supply of alcohol at a reduced price or free of charge to a certain target group • The sale or supply of alcohol at a reduced price to someone because they have already purchased a certain quantity of alcohol or another service • The sale or supply of alcohol during a limited time period (three days or less) that was less than the price charged for the same product the day before the offer was introduced • Promotion of a business or event in a way that is likely to encourage people to drink alcohol in a harmful manner. | <p>Restricting the sale and supply of alcohol products, particularly restricting price-based promotions, will reduce affordability and availability. Reducing the affordability and availability of alcohol products is the most effective way of reducing alcohol consumption at a population level.⁴</p> | <p>Section 23 was commenced in November 2018.</p> |

Summary of the Act

Table 1 summarises some of the main provisions in the Act, their rationale, the measures introduced thus far, and those yet to be commenced.

Conclusion

The Public Health (Alcohol) Act 2018 provides a number of evidence-based measures designed to reduce alcohol consumption at a population level. The first restrictions around alcohol advertising have now become law and several other provisions have been commenced. Timely implementation of the remaining provisions is needed given the current high rates of alcohol consumption, binge drinking, and alcohol dependence in Ireland.^{8,9}

Claire O'Dwyer

1 Government of Ireland (2018) Public Health (Alcohol) Act 2018. Available online at: <http://www.irishstatutebook.ie/eli/2018/act/24/enacted/en/html>

2 Cousins G, Mongan D, Barry J, Smyth B, Rackard M and Long J (2016) Potential impact of minimum unit pricing for alcohol in Ireland: evidence from the National Alcohol Diary Survey. *Alcohol Alcohol.*, 51(6): 734–40. <https://www.drugsandalcohol.ie/26346/>

3 Alcohol Action Ireland (2019) *Annual alcohol market review and price survey 2019*. Dublin: Alcohol Action Ireland. Available online at: <https://alcoholireland.ie/alcohol-action-ireland-release-annual-alcohol-market-review-price-survey-2019/>

4 Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, *et al.* (2010) *Alcohol: no ordinary commodity: research and public policy*. 2nd edn. Oxford: Oxford University Press. <https://www.drugsandalcohol.ie/16134/>

5 O'Dwyer C and Mongan D (2019) Public awareness of alcohol-related health conditions in Ireland: findings from the Healthy Ireland Survey. *Drugnet Ireland*, 70: 19–21. <https://www.drugsandalcohol.ie/31013/>

6 Anderson P, de Bruijn A, Angus K, Gordon R and Hastings G (2009) Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol Alcohol*, 44(3): 229–43.

7 Hingson RW, Heeren T and Winter MR (2006) Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Arch Pediatr Adolesc Med*, 160(7): 739–46.

8 Department of Health (2018) *Healthy Ireland Survey 2018: summary of findings*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/29851/>

9 Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a National Alcohol Diary Survey*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/22138/>

What Works: Sharing Knowledge, Improving Children's Futures

The initiative of the Department of Children and Youth Affairs (DCYA), What Works: Sharing Knowledge, Improving Children's Futures, was launched by Minister Katherine Zappone on 19 June 2019. The event brought together key stakeholders in policy, provision, and practice communities.

What Works is a rebrand of the Quality and Capacity Building Initiative (QCBI) that DCYA has been developing since 2016. What Works seeks to embed and enhance knowledge and quality in prevention and early intervention in children and young people's policy, service provision, and practice. There is a number of core strands to this work, including a data working strand; an evidence working strand; a professional development and capacity-building working strand; and finally a quality working strand.

Data working strand

The data working strand aims to improve access and use of data and information relating to children, young people, and their families by aligning and developing what currently exists in this area. The Outcomes for Children Data & Information Hub – <https://outcomes4children.tusla.ie> – which was also launched on 19 June, sets out to deliver on this aim. It aims to provide a sustainable, standardised technical solution for mapping outcomes and indicators for children and young people to aid in service planning, design, and delivery. It has been developed by Tusla, the Child and Family Agency, in conjunction with DCYA. It is publicly accessible and provides a web-based platform to visualise published data sets.

Evidence working strand

The evidence working strand aims to harness the learning from prevention and early intervention initiatives and research in order to actively support the use of this learning as a source and resource to inform planning, delivery, evaluation, and continuous improvements. This aim is in part met by the launch

on 19 June of a dedicated website – <https://whatworks.gov.ie> – which sets out to be a 'go to' source on what works best in prevention and early intervention in improving outcomes for children, young people, and their families. It is planned as a knowledge-exchange platform through which information on practice approaches, toolkits, practice guides, professional learning opportunities, and interventions and programmes can be accessed. However, an 'evidence matrix'¹ continues to be in the planning phase; this will involve the design of an 'open access online guide/clearinghouse which will provide details and rated assessment of the costs and standards of evidence of impact of prevention and early intervention evidence based programmes globally and in Ireland' (p. 3).¹

Professional development and capacity-building working strand

The professional development and capacity-building working strand sets out to enhance the capacity and skills development of policymakers, providers, and practitioners in the appraisal and application of evidence-informed approaches in prevention and early intervention for children and young people through capacity building and development. The planned output under this working strand has evolved from being a standardised module of training in prevention and early intervention to a broader range of supports aimed at professional groupings in areas of need. A learning framework is under development but some of the related activities have been initiated. For example, DCYA's partnership with the University of Limerick in the Research Evidence into Policy Programmes and Practice Project delivers short, focused executive leadership programmes in geographic/practice communities across Ireland. Action Learning Workshops with DCYA grantees have also been delivered.

Quality working strand

The quality working strand sets out to align, enhance, and sustain quality in prevention and early intervention as it relates to the development and delivery of policy, provision, and practice for children and young people. Development work is ongoing under this strand.

Lucy Dillon

¹ Department of Children and Youth Affairs (2018) *Request for tenders 27 April 2018 for the development of evidence matrix for the Quality and Capacity Building Initiative*. Dublin: Department of Children and Youth Affairs. <https://www.drugsandalcohol.ie/29299/>

Planet Youth in WRDATF

In 2018, the Western Region Drug and Alcohol Task Force (WRDATF) committed itself to supporting the implementation of Planet Youth in parts of the region.¹ As a first step, data were collected using the standardised Planet Youth tool with students in schools in participating areas. The results of these surveys are available on the programme's Irish site, <http://www.planetyouth.ie> – launched in May 2019.

Planet Youth

Planet Youth is an evidence-based approach to preventing drug use. Developed in Iceland, the prevention model is predicated on three pillars of success: using evidence-based practice; using a community-based approach; and creating and maintaining a dialogue among research, policy, and practice. As outlined in more detail in an article in issue 66 of *Drugnet Ireland* in 2018, there are three broad elements to the model.¹ First, data are collected from young people (aged 15–16 years) through a school-based lifestyle questionnaire that is carried out biennially. This explores background factors, substance use, social circumstances, and potential risk factors associated with substance use. These data are then analysed to identify

Table 1: Findings related to substance misuse from the Planet Youth survey – percentage that reported activities

| Lifestyle activity | Galway (%) | Mayo (%) | Roscommon (%) |
|----------------------------------------------|-------------|-------------|---------------|
| Being drunk more than once in their lifetime | 47 | 45 | 48 |
| Being drunk in the last month | 27 | 26 | 25 |
| Lifetime cannabis use | 19 | 15 | 17 |
| Lifetime ecstasy use | 4 | 2 | 3 |
| Lifetime tranquiliser use | 10 | 8 | 6 |
| Drinking in pubs and clubs | 19 | 23 | 27 |
| Drinking in the homes of friends | 26 | 26 | 32 |
| Number of participants | 2613 | 1397 | 480 |

the scope of the problem and map out the risk and protective factors experienced by the young people in that area. The second element is where local stakeholders use the findings to plan and deliver a set of prevention responses – stakeholders include researchers, policymakers, practitioners, parents, school personnel, sports facilitators, recreational and extracurricular youth workers, and other interested community members. The third element is described as ‘integrative reflection’ (p. 19),² whereby the impact of the interventions is measured through regular data collection, interventions amended in response to the findings, and any new issues identified.

Planet Youth in WRDATF

There are three Planet Youth pilot sites in Ireland – Planet Youth Galway, Planet Youth Mayo, and Planet Youth Roscommon. Each site has committed to a five-year pilot programme initiated by WRDATF with the support of partner agencies in the region. Local steering committees have been set up, which include funders and strategic partners. Data have been collected through the standardised lifestyle questionnaire in each of the three areas. A separate report has been produced for each area that includes the findings from each of the 77 questions and a variety of cross-tabulations.^{3,4,5}

Findings

Table 1 shows the findings relating to substance misuse from the Planet Youth survey across the three pilot sites.

Other key findings included:

- Participants across the three counties who are involved in a sports club or a team are less likely to smoke cigarettes or use cannabis, but are more likely to report drunkenness.
- 30–32% agree somewhat or agree strongly that it is important to drink so that you are not left out of the peer group.
- Teenagers whose parents are less disapproving of drunkenness are more than twice as likely to have been drunk in the last month in Roscommon and Galway. This increased to two and a half times as likely in Mayo.
- Being out after midnight was associated with increased substance use. For example, in Mayo, teenagers who reported being out after midnight once or more in the past week were five times more likely to use cigarettes, two and a half times more likely to report drunkenness, and three times as likely to use cannabis.

Conclusions and recommendations

Across the three reports, the authors draw the same conclusions from the data and make the same set of recommendations. Conclusions drawn include:

- There are positive findings around protective factors for young people in the area that could be used to shape primary prevention activities. The majority have good relationships with their parents and report being happy and safe in their schools and communities. Parent and family factors scored very highly with strong connections between parents and high levels of parental support and monitoring.
- The findings reflect what the authors term a ‘broad societal tolerance’ towards underage alcohol use. Alcohol use is seen as an integral part of Irish social life and also has a role in cultural and sporting activities. This cultural accommodation ‘permeates into adolescent decision-making and norms and needs to be challenged’. In contrast, other drugs are not socially accepted in the same way and therefore are used less frequently and are not as tolerated in family or peer settings.
- A large proportion of young people in the three areas are active in sports and other extracurricular activities. The authors would have expected this to have been a protective factor for all substances, but it is not the case in any of the areas when it comes to alcohol use. They argue that consideration needs to be given as to why this is the case.
- Based on these findings, the authors make seven recommendations, under each of which is a set of suggested actions. The top level recommendations are:
 - 1 Improve parental knowledge of the impact of alcohol and other drugs.
 - 2 Utilise the strong connections and communication between young people and their parents.
 - 3 Strengthen collaboration and connections between families.
 - 4 Improve parental knowledge of the impact of unstructured leisure time on substance use.
 - 5 Increase knowledge of peer factors related to substance use.
 - 6 Utilise and develop parental networks.
 - 7 Decrease peer-facilitated access to alcohol and other substances.

Planet Youth in WRDATF continued

Lucy Dillon

- 1 Dillon L (2018) Planet Youth. *Drugnet Ireland*, 66 (Summer): 24. <https://www.drugsandalcohol.ie/29607/>
- 2 Sigfúsdóttir ID, Thorlindsson T, Kristjánsson AL, Roe KM and Allegrante JP (2009) Substance use prevention for adolescents: the Icelandic Model. *Health Promot Int*, 24(1): 16–25. <http://www.drugsandalcohol.ie/28656/>

- 3 Western Region Drug and Alcohol Task Force (WRDATF) (2019) *Growing up in the west: county report Mayo*. Galway: WRDATF. <https://www.drugsandalcohol.ie/30531/>
- 4 Western Region Drug and Alcohol Task Force (WRDATF) (2019) *Growing up in the west: county report Roscommon*. Galway: WRDATF. <https://www.drugsandalcohol.ie/30532/>
- 5 Western Region Drug and Alcohol Task Force (WRDATF) (2019) *Growing up in the west: county report Galway*. Galway: WRDATF. <https://www.drugsandalcohol.ie/30528/>

Progress report on national drugs strategy for 2018

Ireland's national drugs strategy *Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017–2025* was launched in July 2017.¹ The first progress report on the strategy was published in June 2019, namely *Reducing harm, supporting recovery: progress 2018 and planned activity 2019*.²

The progress report is structured around the three-year action plan that accompanied the strategy. The strategic action plan 2017–2020 was embedded in the main strategy document and contains 50 actions with a brief description of how each is to be delivered. Lead agencies as well as any associated partners with responsibility for the delivery of each action are also identified.

The strategy sets out a number of ways in which progress on its delivery would be monitored and assessed. Among these was that 'the key bodies responsible for delivering the strategic actions will be required to report on progress on an annual basis to the Minister with responsibility for the National Drugs Strategy' (p. 73).¹ For this report, alongside each action, those responsible for its delivery were invited to report on progress in 2017 and 2018, as well as 'planned activity' for 2019 and 2020.

The Drugs Policy Unit of the Department of Health is responsible for collating this feedback, and this report presents the first output from this work. The information reported is descriptive of tasks and activities carried out rather than of outcomes achieved. While information is not provided for all actions, it does provide a useful overview of progress in line with the strategic action plan 2017–2020.

Lucy Dillon

- 1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 2 Department of Health (2019) *Reducing harm, supporting recovery: progress 2018 and planned activity 2019*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/30660/>

Hidden Harm strategic statement

As previously reported in issue 69 of *Drugnet Ireland*,¹ the Health Service Executive (HSE) and Tusla, the Child and Family Agency, jointly launched the Hidden Harm strategic statement, *Seeing through hidden harm to brighter futures*,² in January 2019. The strategic statement outlines how these two State agencies will work together to bridge the gap between adult and children's services in favour of a more family-focused approach in identification, assessment, and treatment that will improve the wellbeing and minimise the risk of hidden harm to children and families affected by alcohol and drug use.

Hidden harm definition

The experience of children living with parental problem alcohol and other drug use, and the resultant effect on them, is widely known as 'hidden harm'. There are two key features to this term: first, the children are often not known to services; and, second, they suffer harm in a number of ways as a result of compromised parenting, which can impede the child's social, physical, and emotional development (p. 8).²

Context

It is widely accepted that this is a significant problem in Irish society. Addressing hidden harm is a priority for Government, as reflected in the policy documents *Better outcomes, brighter futures* and *Reducing harm, supporting recovery*.^{3,4} Under the national drugs strategy's first goal, to promote and protect health and wellbeing, Tusla and the HSE are the lead agencies on the strategic action to 'mitigate the risk and reduce the impact of parental substance misuse on babies and young children' (p. 31).⁴ Through the National Hidden Harm Project, they have committed to working together in a planned way to improve services and outcomes for children affected by parental problem alcohol and other drug use in Ireland.

Strategic statement

The strategic statement reflects this commitment and is grounded in an extensive body of work by stakeholders. This includes the work of the North South Alcohol Policy Advisory Group's Subgroup on Hidden Harm; the Hidden Harm National Steering Group; learnings from national practice sites and input from a variety of stakeholders, including practitioners and managers from the Drug and Alcohol Task Forces, HSE Drug and Alcohol Services, and Tusla. It is seen by its authors as laying out 'the national standard upon which Hidden Harm work should be measured' (p. 15).² It applies not only to staff of both State

Hidden Harm strategic statement

continued

agencies but also to all voluntary and community groups in receipt of funding from HSE and Tusla, including the Drug and Alcohol Task Forces and their funded projects.

Vision of strategic statement

The vision of the statement is for the two agencies 'to work together effectively at the earliest possible stage to support children and families' (p. 28). At its core, it focuses on the joint working and connecting practice of relevant stakeholders. To deliver on the vision, the statement outlines sets of strategic objectives, shared principles for partners, and common practice standards to guide practitioners:

Partnership may be described in this context as 'joint business' between Tusla and the HSE. It is not expected that HSE Drug and Alcohol service staff become specialists in child welfare and protection, nor that Tusla staff become expert in drug and alcohol treatment and therapy. Rather, that through the implementation of this Statement, both Tusla and HSE staff develop deeper knowledge and practice application on Hidden Harm in a complementary way. (p. 17)²

Other activities

The statement is part of a suite of activities and outputs coming from this joint working. Other components are:

- **Hidden Harm Practice Guide:** This is an 'educational resource to enhance knowledge and skills, in identifying and responding effectively to parental problem alcohol and other drug use in terms of its impact on children and to support the continuing professional development of health and social care practitioners' (p. 2).⁵

- **Information leaflet for practitioners:** Opening our eyes to Hidden Harm aims to help frontline workers support children and young people affected by parental alcohol and other drug use. It includes key messages on the nature of hidden harm and how to find and offer support.⁶
- **National interagency training programme for staff groups working within HSE and Tusla:** This will be based on the practice guide and will encompass areas such as alcohol and drug theoretical frameworks and practice; child development and the impact of problem alcohol and other drug use; and attendant difficulties of mental health and domestic violence on parenting ability.

Lucy Dillon

- 1 O'Dwyer C (2019) Launch of new Hidden Harm initiative. *Drugnet Ireland*, 69 (Spring): 1–3. <https://www.drugsandalcohol.ie/30627/>
- 2 Health Service Executive (HSE) and Tusla (2019) *Hidden Harm strategic statement: seeing through hidden harm to brighter futures*. Dublin: HSE and Tusla. <https://www.drugsandalcohol.ie/30190/>
- 3 Department of Children and Youth Affairs (2014) *Better outcomes, brighter futures: the national policy framework for children and young people 2014–2020*. Dublin: Stationery Office. <https://www.drugsandalcohol.ie/21773/>
- 4 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 5 Health Service Executive (HSE) and Tusla (2019) *Hidden Harm practice guide: seeing through hidden harm to brighter futures*. Dublin: HSE and Tusla. <https://www.drugsandalcohol.ie/30190/>
- 6 North South Hidden Harm Group (2019) *Opening our eyes to Hidden Harm: empowering frontline workers to support children and young people affected by parental problem alcohol and other drug use*. Dublin: HSE and Tusla. <https://www.drugsandalcohol.ie/30190/>



Minister of State at the Department of Health with responsibility for Health Promotion and the National Drugs Strategy Catherine Byrne TD opening the 2019 National Drugs Forum in Croke Park on 5 November

Headshop legislation and changes in drug-related psychiatric admissions

The impact of changes in legislation on drug-using behaviour is an area of interest for policymakers and other stakeholders. In 2017, a paper by Smyth *et al.* explored the relationship between changes in Ireland's legislation related to new psychoactive substances (NPS) and their problematic use by looking at national drug treatment data.¹ While acknowledging other possible explanations, the authors argued that their findings 'are consistent with a hypothesis that the legislation and consequent closure of the headshops contributed to a reduction in NPS-related substance use disorders in Ireland'. They concluded that:

While policy responses based on prohibition type principals appear to have fallen out of favour globally in the past decade, the experience of Ireland's response to NPS suggests that such policies remain a legitimate component of society's response to this complex and ever-changing challenge.

A 2019 paper by Smyth *et al.* builds on this analysis by exploring the same research question using drug-related psychiatric admissions (DRPAs) data rather than treatment data.²

Context

As outlined in a *Drugnet Ireland* article on Smyth *et al.*'s 2017 paper, in 2010, NPS were the subject of two pieces of legislation in Ireland.³ The first (enacted in May 2010) expanded the list of substances controlled under the Misuse of Drugs Acts 1977–1984 to include over 100 NPS.⁴ The second, the Criminal Justice (Psychoactive Substances) Act 2010 (enacted in August 2010), differed from the established approach to drug control under Ireland's Misuse of Drugs Act, in that it covered the sale of substances by virtue of their psychoactive properties, rather than the identity of the drug or its chemical structure. It was aimed at vendors of NPS and effectively made it an offence to sell a psychoactive substance.⁵ This 'two-pronged legislative approach' was largely in response to an increase in the number

of so-called 'headshops' selling NPS from late 2009 to a peak of 102 premises in May 2010. By October 2010, only 10 headshops were still open and by late 2010 An Garda Síochána indicated that none of the remaining shops were selling NPS.

Legislative bans such as these have attracted international debate as to their effectiveness in impacting on the overall availability and use of NPS, in particular problematic use.⁶ In their 2019 paper, Smyth *et al.* hypothesised that 'the expansion and subsequent abrupt closure of headshops in Ireland might cause changes to acute psychiatric presentations linked to NPS' (p. 2).

Methods

The paper is based on analysis of data from the National Psychiatric In-Patient Reporting System (NPIRS) database, which collates data from every psychiatric inpatient unit in the Republic of Ireland. When a patient is discharged from one of these units, the clinical team identifies the primary and any additional diagnoses that led to an admission. Smyth *et al.* focused on DRPAs defined as either primary or any secondary discharge diagnosis that was in the F11–F19 ICD-10 diagnostic categories (International Statistical Classification of Diseases and Related Health Problems). Analysis included all DRPAs between 2008 and 2012 of people aged between 18 and 34 years. As there is no unique patient identifier in Ireland, the unit of analysis was episode of admission, not individual patient. Data are not collected on the drug used by the DRPA, so analysis is not linked specifically to NPS.

Statistical analysis was carried out to answer three core questions:

- **Do DRPAs differ from other admissions in the age range 18–34?** To contrast proportions, the authors used chi-squared tests, reporting odds ratios and estimates of the 95% confidence interval (CI). Twelve per cent of all admissions for the period under study (2008–2012) were DRPAs. When compared with non-drug-related admissions, DRPAs were more likely to be male, younger, have unstable accommodation, be single/divorced, and have less skilled work.
- **Did the rate of DRPA increase during the 'headshop era' (January–August) in 2010?** The authors found that the rates of admission in 2010 were significantly higher than in 2008, 2009, and 2012 ($p < 0.01$) (see Table 1).
- **Was there evidence of trend changes in DRPA and did these coincide with the arrival and departure of the headshops?** The authors used the Joinpoint regression

Table 1: Rates of drug-related psychiatric admissions per month among 18–34-year-olds, comparing the headshop era of January to August 2010 with the same period in other years

| Year | Monthly rate/100 000 | | Comparison with 2010 |
|------|----------------------|--------------|----------------------|
| | Median | (IQR) | P value |
| 2008 | 4.8 | (3.9 to 5.7) | 0.003 |
| 2009 | 5.0 | (4.4 to 5.6) | 0.005 |
| 2010 | 6.1 | (5.6 to 6.6) | n/a |
| 2011 | 5.7 | (4.9 to 6.0) | 0.065 |
| 2012 | 5.0 | (4.9 to 5.8) | 0.003 |

Source: Smyth *et al.*, 2019, Table 3, p. 52

IQR = Interquartile range.

Headshop legislation continued

analysis that identified a significant downward trend change, which occurred in July 2010 (85% CI: Feb 2010 to April 2011). Males aged 18 to 24 years showed the greatest change, with DRPA falling by 1.4% per month (95% CI: 0.7 to 3.7% decline) from May 2010 to December 2012.

Conclusion

The authors argue that the timing of the changes found coincide with the advent of the headshop era and the subsequent introduction of legislation that essentially banned the sale of NPS in Ireland. In their discussion, the authors present these findings alongside the reduction in NPS-related treatment episodes found in their 2017 paper, and an 80% decline in NPS youth over the 4 years following 2010.⁷ The authors use this evidence to argue that while they recognise that correlation does not prove causation, their 'findings lend weight to the view that the steps taken in Ireland to address NPS were associated with a positive public health impact' (p. 7).

Lucy Dillon

- 1 Smyth BP, Lyons S and Cullen W (2017) Decline in new psychoactive substance use disorders following legislation targeting headshops: evidence from national addiction treatment data. *Drug Alcohol Rev*, 36(5): 609–17. <http://www.drugsandalcohol.ie/27172/>
- 2 Smyth BP, Daly A, Elmusharaf K, McDonald C, Clarke M, Craig S, et al. (2019) Legislation targeting head shops selling new psychoactive substances and changes in drug-related psychiatric admissions: a national database study. *Early Interv Psychiatry*. Early online. <https://www.drugsandalcohol.ie/30436/>
- 3 Dillon L (2017) Headshop legislation and changes in national addiction treatment data. *Drugnet Ireland*, 62 (Summer): 13–14. <https://www.drugsandalcohol.ie/27740/>
- 4 Misuse of Drugs (Amendment) Regulations 2010. Available online at: <http://www.irishstatutebook.ie/eli/2010/si/200/made/en/pdf>
- 5 Criminal Justice (Psychoactive Substances) Act 2010 (Commencement) Order 2010. Available online at: <http://www.irishstatutebook.ie/eli/2010/si/401/made/en/pdf>
- 6 Dillon L (2016) New psychoactive substances: legislative changes in the UK. *Drugnet Ireland*, 59 (Autumn): 9–10. <http://www.drugsandalcohol.ie/26231/>
- 7 National Advisory Committee on Drugs and Alcohol (NACDA) (2016) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland 2014/15: Regional Drug and Alcohol Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) results. Bulletin 2*. Dublin: NACDA. <https://www.drugsandalcohol.ie/26901/>

Meeting the needs of BME communities – organisational connector models

In 2017, CityWide Drugs Crisis Campaign produced the report, *Stimulating and supporting a black and minority ethnic voice on drug issues*.¹ The research aimed 'to explore possible structures and processes through which to engage with, hear the voice of, and empower Black and minority ethnic [BME] communities in relation to issues of drug use' (p. 5). The report concluded that problematic drug use was an issue facing BME communities in Ireland, that there were challenges in addressing it, and that the needs of these communities were not being met by policymakers or service providers. A summary of the key findings of this report was provided in a 2018 issue of *Drugnet Ireland*.² As a follow-up to this report, in 2019, CityWide published *Taking steps to engage with black and minority ethnic communities and their organisations on issues related to problematic drug use*.³ As with the previous report, the current one is written by Niall Crowley, an independent public policy researcher with expertise in human rights and equality.

Taking steps outlines the measures that can be taken by policymakers, service providers, Drug and Alcohol Task Forces (DATFs), and BME community organisations to better address the needs of BME communities in relation to problematic drug use. It describes two organisational connector models. In terms

of definition, organisational connectors are described as 'local organisations that have a strong relationship with and include members of Black and minority ethnic communities in their day-to-day work. They include schools, youth organisations, churches and minority ethnic businesses' (p. 10). Organisational connectors enable service providers to more effectively engage and communicate with BME communities. Two models of working with organisational connectors based on the experiences of two DATFs and other service providers form the main body of the report.

Engaging and networking with schools and youth organisations

The DATF in Dublin's north inner city engaged and networked schools and youth organisations as organisational connectors in making links with BME communities. The aim of their collaboration was to ensure that young BME people were supported, in integrated settings, to access information in relation to problematic drug use; explore and develop their thinking in relation to drug use; and build a network of supportive contacts.

- **Key steps for the DATF included:** Liaising with home school liaison officers and school principals; getting relevant youth organisations involved in its structures and work processes; and developing accessible materials on available supports that took account of the diversity of young people in their area.
- **Key steps for the schools included:** Facilitating and supporting the work of the DATF and local youth organisations, particularly supporting the participation of young people from BME communities to these activities.
- **Key steps for the youth organisations included:** Creating the conditions for integrated activities and building a culture of equality and celebrating diversity.

Meeting the needs of BME communities continued

Engaging local development companies

The Cork Local Drug and Alcohol Task Force engaged with Cork City Partnership (CCP) to make links with BME communities in their area. CCP is a local development company and implements the Social Inclusion and Community Activation Programme (SICAP), which aims to strengthen community development, provide education and training, and support employment. The aim of their collaboration included more involvement of BME communities in the workings of the local DATF and expanding the resources available to respond to and prevent problematic drug and alcohol use within these communities. As well as providing opportunities to interact with BME communities, as a local development company with a remit to address social exclusion and inequality, CCP can provide opportunities to access education, training, and employment programmes.

Conclusion

The report concludes with an extract from CityWide's submission to the Health Service Executive's consultation for the Second National Intercultural Health Strategy 2018–2023, which was launched in January 2019.⁴ It has an action to implement the relevant elements of the national drugs strategy, *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*.⁵

Lucy Dillon

- 1 Crowley N (2017) *Stimulating and supporting a black and minority ethnic voice on drugs issues*. Dublin: CityWide Drugs Crisis Campaign. <https://www.drugsandalcohol.ie/27501/>
- 2 Dillon L (2018) Problematic drug use and the needs of new communities and BME groups. *Drugnet Ireland*, 64 (Winter): 26–27. <https://www.drugsandalcohol.ie/28577/>
- 3 Crowley N (2018) *Taking steps to engage with black and minority ethnic communities and their organisations on issues related to problematic drug use*. Dublin: CityWide Drugs Crisis Campaign. <https://www.drugsandalcohol.ie/30443/>
- 4 Health Service Executive (2018) *Second National Intercultural Health Strategy 2018–2023*. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/30767/>
- 5 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>

PREVALENCE AND CURRENT SITUATION

Has an increase in the dispensing of pregabalin influenced poisoning deaths in Ireland?

Introduction

Deaths caused by the toxic effect of drugs (poisoning deaths) are preventable and good clinical practice with supporting legislation can help prevent such deaths. Irish data on poisoning deaths show an increase in direct pregabalin-related poisoning deaths from the years 2013 to 2016.¹ Of note, pregabalin – a prescribed medicine used in the treatment of several medical conditions, including epilepsy, neuropathic pain, and generalised anxiety disorder – has only been included in the routine postmortem toxicology screen by the State Laboratory since 2013.

Following the introduction of pregabalin in 2004, international evidence found an increase in its prescription rates.^{2,3,4} Fatal overdoses related to pregabalin have been reported and are almost always in combination with other drugs.^{5,6} The aim of this study was to examine whether or not the increase in the

dispensing of pregabalin has impacted on poisoning deaths in Ireland between 2013 and 2016.

Methods

Prescription data were retrieved from the Health Service Executive (HSE) Primary Care Reimbursement Service (PCRS) annual reports,⁷ which record payment and prescription frequency for several services in Ireland. These services include the General Medical Services (GMS), which in 2014 related to 43% of the general population,⁸ and services that cover the remainder of the population; data on drugs provided through the Long-Term Illness Scheme (LTI), which covers free drugs for the treatment of specific long-term illnesses; and data on repayments through the Drugs Payment Scheme (DPS), which reimburses any citizen who pays more than a set amount monthly for medicines.

Data on all poisoning deaths for the years of death 2013–2016 with positive toxicology for pregabalin were extracted from the National Drug-Related Deaths Index (NDRDI). The NDRDI is an epidemiological census which records all poisoning deaths by drug(s) and/or alcohol. It also records non-poisonings deaths among persons who have a history of drug and/or alcohol dependence or misuse of drugs. The NDRDI's main data source is coronial files. All postmortem toxicological analyses included in this report were performed by the State Laboratory in Ireland. Further details on the NDRDI methodology can be found in a previous Health Research Board publication.⁹ Descriptive statistics are presented for the number of dispensings and deaths over time. In addition, correlational analysis using linear regression was applied to estimate the relationship between number of dispensings for pregabalin and deaths over the reported time period.

Pregabalin influenced poisoning deaths continued

Results

For the years of death 2013–2016 inclusive, the NDRDI recorded a total of 1489 poisoning deaths. Pregabalin was present on toxicology reports of 240 (16%) poisoning deaths during this period, increasing from 18 (4.5%) in 2013 to 94 (26%) in 2016,

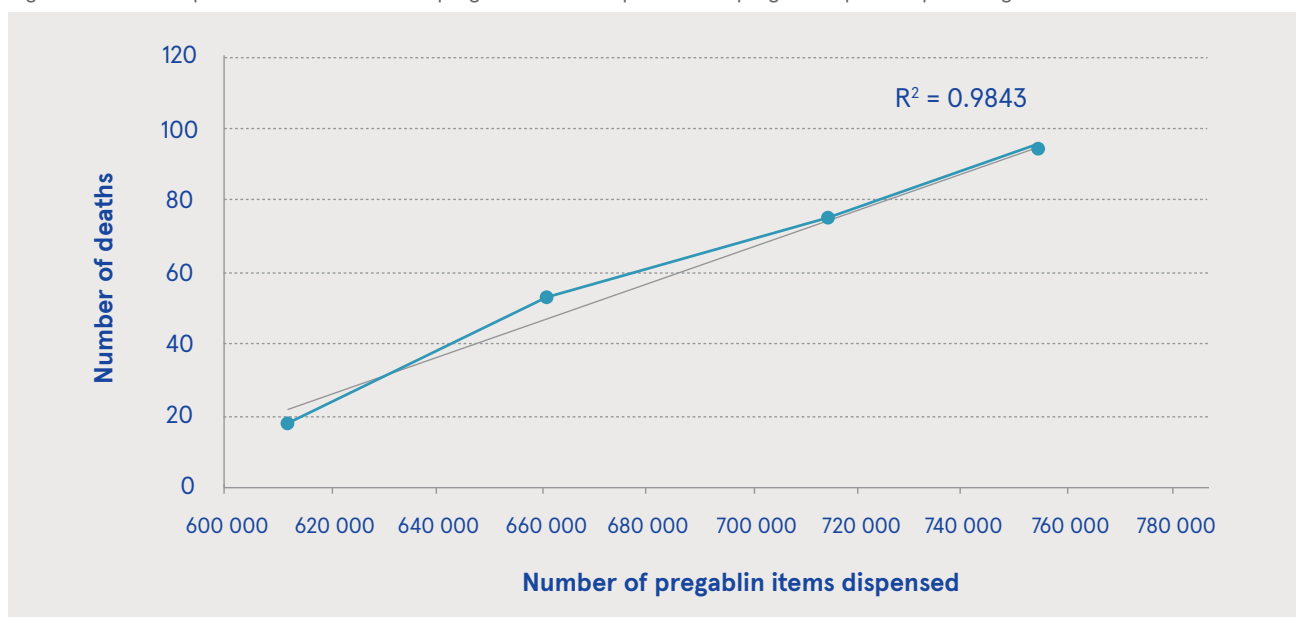
indicating an upward trend ($\chi^2 = 74.626$, $p < 0.001$) in the presence of pregabalin in poisoning deaths (see Table 1). The numbers of dispensed pregabalin items are shown in Table 1; these numbers increased year on year. Figure 1 shows a strong positive correlation between the number of pregabalin items dispensed through the HSE PCRS scheme and the number of poisoning deaths where pregabalin was present on toxicology reports over time, with a coefficient (R^2) value of 0.9843.

Table 1: PCRS pregabalin dispensing frequency, number of poisoning deaths with a pregabalin-positive toxicology, and percentage of deaths related to PCRS dispensing, by year, 2013–2016

| Year of death | 2013 | 2014 | 2015 | 2016 |
|----------------------------------------------------------------|---------|---------|---------|---------|
| Total PCRS pregabalin items dispensed* | 612 641 | 661 788 | 715 502 | 755 159 |
| <i>Breakdown of PCRS pregabalin items by scheme:</i> | | | | |
| GMS | 519 187 | 559 421 | 608 801 | 652 013 |
| DPS | 85 210 | 89 183 | 89 844 | 85 321 |
| LTI | 8244 | 13 184 | 16 857 | 17 825 |
| All NDRDI poisoning deaths | 400 | 370 | 365 | 354 |
| Pregabalin-positive toxicology poisoning deaths | 18 | 53 | 75 | 94 |
| Percentage of deaths related to pregabalin items dispensed (%) | 0.0029 | 0.008 | 0.01 | 0.012 |

*These figures do not include private pregabalin items dispensed that do not fall into these categories.

Figure 1: Relationship between the number of pregabalin items dispensed and pregabalin-positive poisoning deaths, NDRDI 2013–2016



Discussion

This ecological study shows that pregabalin-positive poisoning deaths are increasing in line with the increased dispensing of pregabalin in Ireland. In the United States, it has been suggested that the increase in prescribing pregabalin is related to clinicians using it outside its licensed indicated use, as an alternative to opioids for a variety of pain management.² Since April 2019, in the United Kingdom, following recommendations from the Advisory Council on the Misuse of Drugs,¹⁰ pregabalin (and gabapentin) has been classified as a Class C drug. This means that pregabalin cannot be repeat-dispensed and prescriptions will only be valid for one month. Despite the

acknowledgement that this will incur extra work for doctors, pharmacists, and especially patients, the medical profession in general supports this change.¹¹ Results from our study support the consideration of similar reclassification of pregabalin in Ireland. In Ireland, the HSE issued correspondence in June 2016 in relation to the dangers associated with prescribing pregabalin;¹² however, this needs to be supported with tighter controls through legislative changes.

Ena Lynn

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- 5 Bonnet U and Scherbaum N (2017) How addictive are gabapentin and pregabalin? A systematic review. *Eur Neuropsychopharmacol*, 27(12): 1185–1215.
- 6 Lyndon A, Audrey S, Wells C, Burnell ES, Ingle S, Hill R, *et al.* (2017) Risk to heroin users of polydrug use of pregabalin or gabapentin. *Addiction*, 112(9): 1580–89.
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- 8 Irish Government Economic and Evaluation Service (IGEES) (2017) *General Medical Services Scheme: Staff paper 2016*. Dublin: Department of Public Expenditure and Reform. [Available online at: <http://www.budget.gov.ie/Budgets/2017/Documents/3.%20General%20Medical%20Services%20Scheme.pdf>] [Accessed 25 March 2019] (Archived by WebCite® at <http://www.webcitation.org/778toW8jG>).
- 9 Lynn E, Lyons S, Walsh S and Long J (2009) *Trends in deaths among drug users in Ireland from traumatic and medical causes, 1998 to 2005*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/12645/>
- 10 Advisory Council on the Misuse of Drugs (2016) Letter to the Minister for Preventing Abuse and Exploitation re pregabalin and gabapentin advice. London: Advisory Council on the Misuse of Drugs. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/491854/ACMD_Advice_-_Pregabalin_and_gabapentin.pdf [Accessed 25 March 2019].
- 11 Torjesen I (2019) Pregabalin and gabapentin: what impact will reclassification have on doctors and patients? *BMJ*, 364: 11107.
- 12 Health Service Executive (2016) *Medicines Management Programmes (MMP): Preferred drug initiative. Circular 046/16*. Dublin: Health Service Executive. Available online at: <https://www.hse.ie/eng/staff/pcrs/circulars/gp/preferred%20drugs%20programme.pdf> [Accessed 25 March 2019] (Archived by WebCite® at <http://www.webcitation.org/778ruH8ll>).

National Self-Harm Registry annual report, 2017

The 16th annual report from National Self-Harm Registry Ireland was published in 2018.¹ The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2017 and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol were not included.

Rates of self-harm

There were 11,600 recorded presentations of deliberate self-harm in 2017, involving 9,103 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 199 per 100,000 population. This was 3% lower than the rate recorded in 2016 (206 per 100,000 population). In recent years, between 2011 and 2013, there have been successive decreases in the self-harm rate. Nevertheless, the rate in 2017 was still 6% higher than in 2007, the year before the economic recession (see Figure 1).

In 2017, the national male rate of self-harm was 181 per 100,000 population, 2% lower than in 2016. The female rate was 218 per 100,000 population, which was 4% lower than in 2016. With regard to age, the peak rate for men was in the 20–24-age group, at 505 per 100,000 population. The peak rate for women was among 15–19-year-olds, at 758 per 100,000 population.

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2017, occurring in 7,531 (64.9%) of episodes. As observed in 2016, overdose rates were higher among women (70.3%) than among men (58.1%). Minor tranquillisers and major tranquillisers were involved in 34% and 9% of drug overdose acts, respectively. In total, 33% of male and 47% of female overdose cases involved analgesic drugs, most commonly paracetamol, which was involved in 29% of all drug overdose acts. In 67% of cases, the total number of tablets taken was known, with an average of 29 tablets taken in episodes of self-harm that involved a drug overdose.

There was a 7% increase (n=583) in the number of presentations involving street drugs (cannabis, ecstasy, and cocaine) compared with 2016 (n=547). The 2017 levels are the highest recorded since 2008 and the second-highest ever recorded by the registry. Alcohol was involved in 31% of all self-harm presentations, and was significantly more often involved in male episodes of self-harm than females (33% vs 29%, respectively). The authors reported that, as in previous years, alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, and in the hours around midnight.

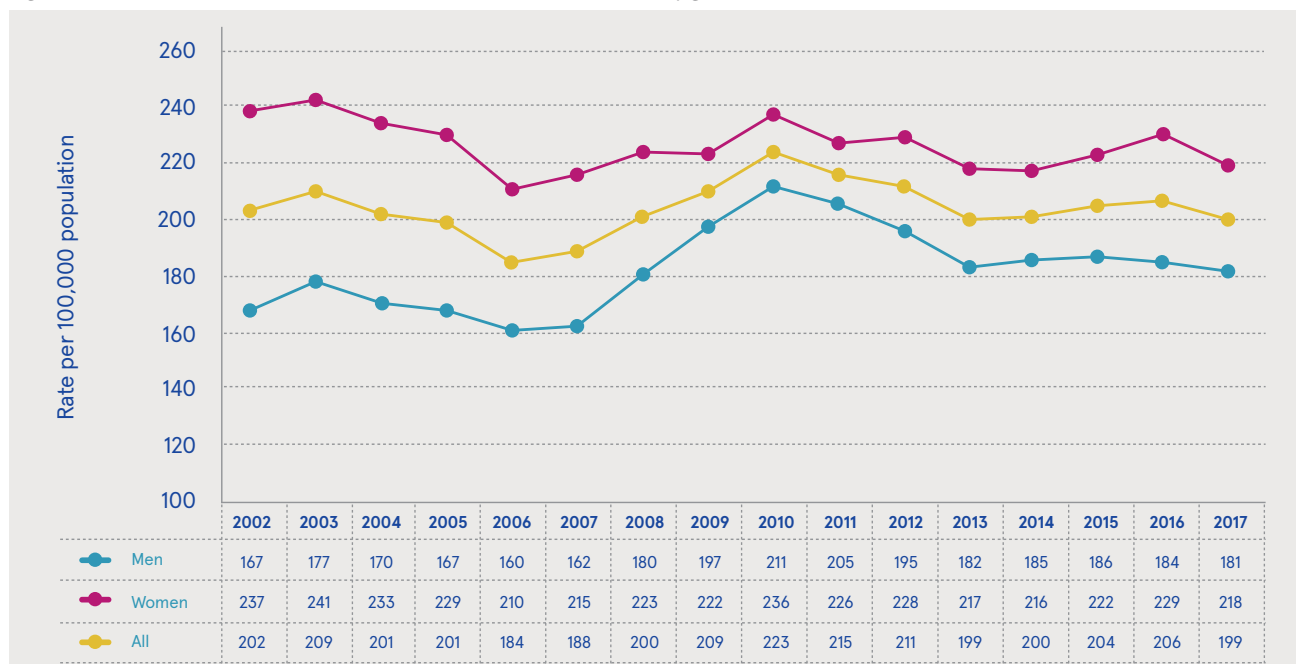
Conclusions

The authors concluded that these findings underline the need for ongoing efforts:

- To reduce access to minor tranquillisers and other frequently used drugs, including paracetamol
- To intensify national strategies to increase awareness of mental health issues
- To intensify further strategies to reduce access to alcohol.

National Self-Harm Registry annual report, 2017 continued

Figure 1: Person-based rate of deliberate self-harm from 2002 to 2017 by gender



Source: National Suicide Research Foundation, 2018

'All' in the legend refers to the rate for both men and women per 100,000 population.

Seán Millar

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Trends in addiction treatment in Irish prisons

In 2008, the National Drug Treatment Recording System (NDTRS) began to collect information on drug treatment in Irish prisons, mainly from in-reach voluntary services which provided counselling only. Up to 2013, the medical units of the Irish Prison Service did not participate in the NDTRS; however, in 2014, the medical unit in the largest male prison provided data on opiate substitution treatment and detoxification. Many studies have shown that incarcerated populations have a higher rate of problem drug and alcohol use compared with the general population. Prison treatment services are therefore an important source of data for gaining a better understanding of the trends in problem drug and alcohol use, and for informing service design and delivery. A recent Irish study¹ analysed trends in addiction treatment demand in prisons in Ireland from 2009 to 2014 using available national surveillance data in order to identify any implications for practice and policy.

In this research, published in the *International Journal of Prisoner Health*, national surveillance data on treatment episodes for problem drug and alcohol use from 2009 to 2014, collected annually by the NDTRS, were analysed. In total, 6% of all treatment episodes recorded by the NDTRS between 2009 and 2014 were from prison services. It was found that the number of prison service treatment episodes increased from 964 in 2009 to 1,063 in 2014. Opiates were the main reason for treatment, followed by alcohol, cocaine, and cannabis (see Table 1). The majority (94–98%) of treatment episodes involved males (median age 29 years) and low educational attainment, with 79.5–85.1% leaving school before completion of second level. The percentage of treatment episodes with a history of ever injecting drugs increased from 20.9% in 2009 to 31.0% in 2014.

The authors observed that this is the first study to analyse treatment episodes in prison using routine surveillance data in Ireland and provides a baseline from which to measure any changes in provision of treatment in prison over time. Research on trends in addiction can help policy development and service planning in addiction treatment in prison, as it provides an insight into the potential needs of incarcerated populations.

Table 1: Number of treatment episodes in Irish prisons and main problem drug, NDTRS (2009–2014)

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|----------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| No. of treatment episodes | 964 | 1096 | 1033 | 913 | 1015 | 1063 |
| % of total committed | 7.8 | 8.0 | 7.4 | 6.6 | 7.8 | 7.9 |
| Main problem drug | | | | | | |
| Opiates | 502 52.1% | 570 52.0% | 435 42.1% | 307 33.6% | 436 42.9% | 471 44.3% |
| Alcohol | 177 18.4% | 167 15.2% | 272 26.3% | 271 29.7% | 268 26.4% | 219 20.6% |
| Cocaine | 146 15.1% | 157 14.3% | 116 11.2% | 114 12.5% | 84 8.3% | 110 10.3% |
| Cannabis | 81 8.4% | 115 10.5% | 104 10.1% | 107 11.7% | 123 12.1% | 121 11.4% |
| Hypnotics and sedatives | 47 4.9% | 73 6.7% | 83 8.0% | 91 10.0% | 92 9.1% | 132 12.4% |
| Stimulants | 8 0.8% | 7 0.6% | 11 1.1% | 9 1.0% | 8 0.8% | 9 0.8% |
| Others* | ** 0.3% | 7 0.6% | 12 1.2% | 14 1.5% | ** 0.4% | ** 0.1% |

Source: Cannon *et al.*, 2019

* Includes volatile inhalants.

** To protect against indirect identification of individuals, items with less than five entries have been removed

Seán Millar

1 Cannon A, Nally F, Collins A, Fay R and Lyons S (2019) Trends in addiction treatment in Irish prisons using national surveillance data, 2009–2014. *Int J Prison Health*, 15(2): 105–13. <https://www.drugsandalcohol.ie/30318/>

Hepatitis C virus screening and treatment in Irish prisons from a governor and prison officer perspective

Unsafe injecting drug use is the main route of hepatitis C virus (HCV) transmission in developed countries, with an estimated 20 million people who inject drugs (PWID) infected worldwide.¹ Over one-half of Irish prisoners report a history of opiate use, with 43% reporting a history of injecting.² A 2000 study estimated the prevalence of HCV infection in the Irish prison population at 37%, increasing to 81% in those with a history of injecting drug use.³ With recent advances in treatment regimes, HCV is now a curable and preventable disease and prisons are a key location to access HCV-infected PWID. However, despite international guidelines recommending that prisons are a priority location for HCV screening and treatment, levels of prisoner engagement in HCV care remain low.

A recent Irish study aimed to explore prison governors' and officers' views on barriers and enablers to HCV screening and treatment.⁴ In this research, published in the BMC journal *Health & Justice*, five focus group sessions were conducted among two grades of security staff: the prison governor and the prison officer. The governor component of the study was national in coverage and included input from 13 of the 15 prisons in the Republic of Ireland. For convenience and due to restricted access to other prison locations, the prison officer focus groups were confined to two Dublin prisons: Mountjoy male prison and the Dóchas Centre female prison.

Results

The following themes relating to barriers and enablers to both HCV screening and treatment emerged from the focus groups.

Priority of safety and security

All focus groups included discussions about issues of security and safety in their prisons. While supportive and understanding of the benefits of prison healthcare, their primary focus was to ensure the safety of both staff and inmates. In particular, prison staff reported security concerns related to the protection of prisoners and how burgeoning gangland feuds and rival factions made their jobs very difficult. This created barriers to both HCV screening and treatment since it reduced face-to-face time with prisoners and medical staff because security staff are required to accompany prisoners to medical appointments.

Concerns about personal risk

A recurring theme throughout the focus groups was concern for personal safety. This concern covered the areas of personal safety and risk of exposure to, and acquisition of, blood-borne viruses, including HCV. Prison officers described a work environment of increasing inter-prisoner violence and severity of assault often leading to open wounds and blood loss.

Lack of knowledge

Lack of knowledge among staff was recognised as a major barrier to HCV screening and treatment. Participants identified the provision of education and training as a means of addressing this knowledge deficit. All grades of staff felt a lack of knowledge in relation to the newer HCV treatments and the risks of transmission impacted on their ability to engage with prisoners on this issue. Participants also identified the lack of knowledge among prisoners as a barrier to HCV treatment; in particular, the inaccurate information being circulated regarding the side-effects of treatment, which were historical and associated with interferon-based treatment.

Concerns regarding confidentiality

Prison officer participants reported that lack of confidentiality was a barrier to HCV screening and treatment. Often breaches in confidentiality were inadvertent and were related to prisoners being called to attend certain clinics that were connected with HCV, addiction treatment or HIV care. A number of officers felt that if issues regarding confidentiality were addressed that more prisoners would approach prison officers to discuss HCV-related concerns and that this might be a resource to educate prisoners on HCV-related issues.

Prisoners' fear of treatment and stigma

A number of participants identified fear of treatment as a barrier to prisoners engaging with health services. Fear of treatment was linked to the side-effects of interferon treatment, liver biopsy, and the concerns about stigma. It was suggested that making screening routine or opt-out had the potential to reduce stigma.

Time of screening

Both prison officer and governor participants favoured a structured and systematic approach to HCV screening. The committal period was identified by all groups as an opportune time to engage prisoners with health services and provide HCV screening. Some prison officers identified other time periods that might be suited to HCV screening. They described 'down times' within the week where routine work was not scheduled and that health-related programmes provided during these times might have the added benefit of relieving boredom for prisoners.

Peer workers

Participants in all focus groups agreed that trained peer workers had the potential to facilitate prisoner engagement with health services, including HCV screening and treatment. The narrative around peer workers included prisoners having more trust in their peer networks than 'The System'.

In-reach hepatology and fibroscanning services

The availability of in-reach hepatology and mobile elastography were seen as enablers to prisoner engagement in HCV care. In particular, the cost-effectiveness and staff-saving benefits of in-reach services were viewed by the governor focus groups as a major benefit. The reduction of risk associated with prisoners having to attend hospital services was also noted.

Hepatitis C virus screening and treatment in Irish prisons continued

Conclusions

The authors noted that although Irish prisons are a key setting to identify and treat HCV-infected PWID, this can only be achieved by the elimination of identified barriers to HCV screening and treatment in Irish prisons. In particular, they suggest that upscaling HCV management in prisons requires an in-depth understanding of all barriers and facilitators to HCV screening and treatment. Engaging prison officers in the planning and delivery of healthcare initiatives may be a key strategy to optimising the public health opportunity that prison provides.

Seán Millar

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- 4 Crowley D, Van Hout MC, Murphy C, Kelly E, Lambert JS and Cullen W (2018) Hepatitis C virus screening and treatment in Irish prisons from a governor and prison officer perspective – a qualitative exploration. *Health & Justice*, 6(1): 23. <https://www.drugsandalcohol.ie/30873/>

Deaths in custody in Irish prisons

In 1997, it was observed that prison suicide patterns in Ireland mirrored those in neighbouring jurisdictions and that numbers had increased markedly over the previous 10 years.¹ A 1999 report noted that although most deaths were judged to be suicides, there had been an increase in deaths due to drug overdoses.² A systematic survey of mental health in Irish prisons found that 69% of prisoners reported significant substance or alcohol misuse issues prior to committal.³ In order to plan preventive measures, an investigation was commissioned by the National Suicide and Harm Prevention Steering Group to review the deaths of prisoners in Ireland between 2009 and 2014.⁴ Coroners' findings were analysed, including postmortem tests, to assess whether drugs played a role or not.

In all, there were 69 deaths in custody over this period, of which 38 were deemed to be not from natural causes. Sixteen cases involved drug overdoses. Another eight deaths, all due to hanging, were linked to drug taking. Drug tests showed that two other deaths were also associated with the use of drugs. The drugs involved in the deaths included non-prescribed benzodiazepines, opiates, cocaine, cannabis, codeine, and other psychoactive substances. Many also had alcohol and prescription drugs in their system.

The investigation noted that 14 of the 38 prisoners died while on temporary release, suggesting that imprisonment may offer partial protection and that continuity of care post-release is crucially important. The study authors suggest that friends and family members who visit prisons should be made aware that bringing in contraband is a major contributory factor to unnatural deaths in custody, including deaths by hanging.

Seán Millar

- 1 Dooley E (1997) Prison suicide – politics and prevention: a view from Ireland. *Crisis*, 18(4): 185–90.
- 2 Department of Justice (1999) *Report of the National Steering Group on Deaths in Prisons*. Dublin: Stationery Office. <https://www.drugsandalcohol.ie/5391/>
- 3 Kennedy HG, Monks S, Curtin K, Wright B, Linehan S, Duffy D, *et al.* (2005) *Mental illness in Irish prisoners: psychiatric morbidity in sentenced, remanded and newly committed prisoners*. Dublin: National Forensic Mental Health Service. <https://www.drugsandalcohol.ie/6393/>
- 4 Iqtidar M, Sharma K, Mullaney R, Kelly E, Keevans M, Cullinane M, *et al.* (2018) Deaths in custody in the Irish prison service: 5-year retrospective study of drug toxicology and unnatural deaths. *BJPsych Open*, 4(5): 401–03. <https://www.drugsandalcohol.ie/30871/>

Self-harm in Irish prisons

There are 12 institutions in the Irish prison system, comprising 10 traditional 'closed' institutions and two open centres, which operate with minimal internal and perimeter security. The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy Prison in Dublin, while the remainder are located in a separate wing of Limerick Prison. Self-harm and suicide are major issues in the prison population, as rates of suicide and lifetime self-harm are higher in prisoners compared with the general population. The rate of suicide in Irish prisons from 2011 to 2014 was 47 per 100,000 prisoners. However, to date, research on suicidal behaviour in Irish prisons has been limited.

The Self-Harm Assessment and Data Analysis (SADA) Project has been set up in Ireland to provide robust information relating to the incidence and profile of self-harm within prison settings as well as individual- and context-specific risk factors relating to self-harm; and to examine patterns of repeat self-harm (both non-fatal and fatal). The Health Service Executive's National Office for Suicide Prevention and the National Suicide Research Foundation assist the Irish Prison Service with data management, data analysis, and reporting. This article highlights findings from a report¹ detailing the first 12 months of data on the analysis of all episodes of self-harm across the Irish prison estate in 2017.

Episodes

Between 1 January and 31 December 2017, there were 223 episodes of self-harm recorded in Irish prisons, involving 138 individuals. The majority of prisoners were male (80%) and the mean age was 32 years. The annual person-based rate of self-harm was 4.0 per 100 prisoners. Thus, an episode of self-harm was recorded for 4% of the prison population. Compared with sentenced prisoners, the rate of self-harm was 2.4 times higher among prisoners on remand (7.4 vs 3.1 per 100), while the rate of self-harm was highest among prisoners aged 18–29 years, at 5.0 per 100 prisoners. Episodes of self-harm were more likely to occur on weekdays, with one in five (22%) episodes occurring

on Tuesdays. More than one-half of episodes (52%) occurred between 2pm and 8pm and a majority of episodes (60%) occurred while prisoners were unlocked from cells. Twenty-six per cent of male prisoners repeated self-harm compared with 16% of female prisoners.

Methods, severity and intent

The most common method of self-harm recorded was self-cutting or scratching, which was present in 62% of all episodes. The other common method of self-harm was attempted hanging, which was involved in 21% of episodes. Methods of self-harm were similar for male and female prisoners. In 39% of self-harm episodes, no medical treatment was required (n=87), while almost one-half (102; 45.7%) of all episodes required minimal intervention/minor dressings or local wound management. One in eight episodes required hospital treatment (30; 13.5%) and four self-harm acts involved loss of life (1.8%).

One-half (121; 54.3%) of self-harm episodes were recorded as having no/low intent, with less than one-third (65; 29.1%) recorded as having medium intent. Approximately, one in six acts was rated as having high intent (37; 16.6%). Suicidal intent varied according to the method involved in the self-harm episode; high intent was recorded in more than two-thirds of attempted hanging episodes (17; 37.0%).

Contributory factors

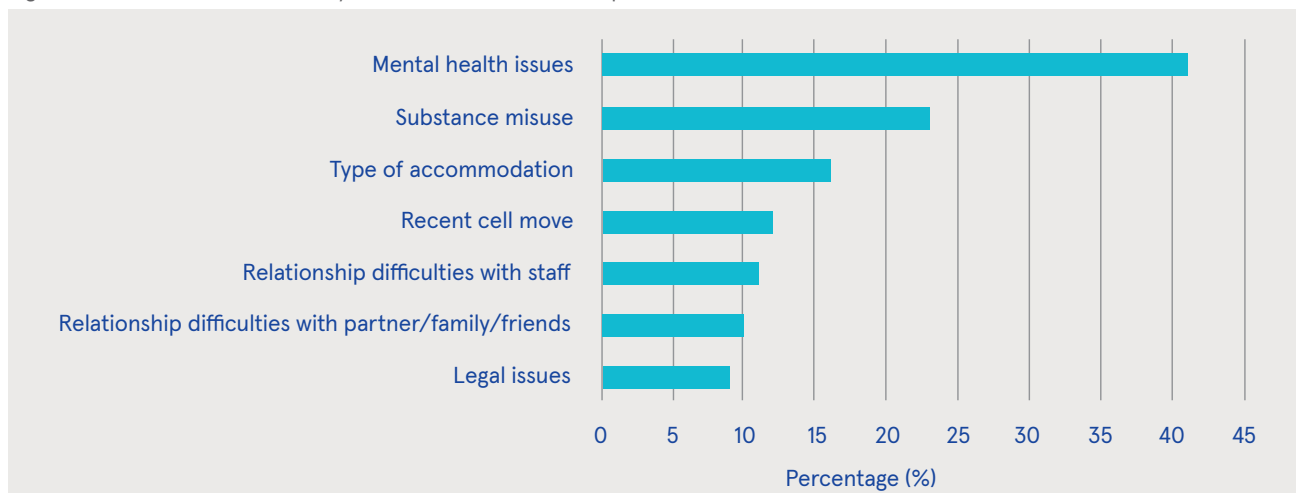
The most common contributory factors to self-harm are shown in Figure 1. The majority of contributory factors recorded related to mental health (129; 57.8%) and a further 84 (37.7%) related to relational issues and 81 (36.3%) to environmental issues. The category of mental health issues included mental disorders as well as problems with coping and emotional regulation. Substance misuse, including drug use as well as drug seeking, was the next most common factor recorded (51; 22.9%). Hopelessness was recorded as a contributory factor in 6.3% and active psychosis/mental illness in 4.5% of self-harm episodes.

Other findings

Other findings highlighted in the report include the following:

- Three-quarters (77%) of self-harm episodes involved prisoners in single cell accommodation.

Figure 1: Most common contributory factors to self-harm in Irish prisons, 2017



Source: Griffin *et al.*, 2018

Self-harm in Irish prisons continued

Seán Millar

- While 44% of prisoners who engaged in self-harm were in general population accommodation, a further 44% were in protection at the time of the self-harm act.
- The four fatal episodes of self-harm involved male prisoners who were on remand. Multiple contributory factors were associated with these deaths.

1 Griffin E, Cully G, Corcoran P, Hume S, Kelly E and O'Reilly D (2018) *Self-harm in Irish prisons 2017. First report from the Self-Harm Assessment and Data Analysis (SADA) Project*. Cork: National Suicide Research Foundation. <https://www.drugsandalcohol.ie/29772/>

RESPONSES

Restorative justice – strategies for change

In June 2019, the collective restorative justice strategy for Ireland was published.¹ The strategy is the first Irish output of a four-year, collaborative cross-European project aimed at helping to embed restorative justice and restorative practices within the Irish criminal justice system.

So, what is restorative justice? The concept has been achieving increased support within criminal justice jurisdictions in many countries for several years. Notably, in Ireland, the idea first emerged in the 1970s, while the practice has been in operation on a statutory basis under the Children Acts 2001–2015 and,

Table 1: Key questions regarding restorative justice in Ireland

| Restorative justice in Ireland: key questions | |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is restorative justice? | Restorative justice is defined by the Criminal Justice (Victims of Crime) Act 2017 in Ireland as 'any scheme administered for the time being under which, with the consent of each of them, a victim and an offender or alleged offender engage with each other to resolve, with the assistance of an impartial third party, matters arising from the offence or alleged offence' (S.2(1)). ⁴ This definition is broadened by the Council of Europe Recommendation, which defines it as 'any process which enables those harmed by crime, and those responsible for that harm, if they freely consent, to participate actively in the resolution of matters arising from the offence, through the help of a trained and impartial third party'. ⁵ |
| What are restorative practices? | The approach used to shape and maintain interpersonal relationships, resolve conflict, and mend broken relationships is known as restorative practice. ⁶ In the context of this project, it refers to the use of a restorative framework within the criminal justice system (CJS). It considers how people who work within or with the CJS interact with each other and the community. In addition, the term represents the approaches used to develop relationships, share information, and establish more comprehensive decision-making processes. |
| Who can participate in restorative justice? | Restorative justice is usually carried out between victims and offenders when it is deemed to be in the best interests of both parties. ¹ The type and circumstances of the offence are also considered. Participation in the process is assessed by trained professionals on a case-by-case basis. |
| When can restorative justice be used? | Restorative justice can be used at all stages of the criminal justice process, for example, as a means of diversion, at pre-sentence and post-sentence stages to assist and support victim recovery, and to manage, rehabilitate and reintegrate offenders, and prevent crime. ¹ Notably, it should not be used instead of a prosecution, in relation to more serious cases; the public interest demands that it should only run in parallel or after a prosecution. |
| Is restorative justice always the same? | How restorative justice is implemented varies and is dependent on several factors: preparation involved (nature, extent, and dynamics), practice, and follow-up needed. Hence, how it is applied in a serious crime involving violence will differ from an acquisitive offence, such as shoplifting or theft. In addition, careful assessment of vulnerability levels, trauma, and mental health experienced will contribute to the decision of how or if restorative justice should take place (p. 4). ¹ Practitioners should have the experience and training that qualifies them to work with the circumstances and vulnerabilities that are presented. |
| How does this work relate to other sectors? | Although this project is centred specifically on the CJS, the authors believe that this work will complement similar work that is being carried out in other areas in Ireland, such as local communities, workplaces, education, and social care settings. |

Source: *Restorative justice: strategies for change*, 2019, pp. 3–4.

Restorative justice continued

Table 2: Strategic pillars of the restorative justice strategy

| No | Strategic pillar | Statement of principle |
|----|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Accessibility | Safe, high-quality restorative justice should be available to all victims and offenders who would benefit from participation. Access should not depend, exclusively and in the absence of other considerations, on where they live in Ireland, their age, the offence in question, or the stage of the criminal justice process. Other affected persons should also be enabled to participate in restorative justice, if victims and offenders so wish. |
| 2 | Knowledge | Restorative justice should be known and understood widely enough and to such an extent that all relevant persons are aware of its potential benefits and risks, and the available services. |
| 3 | Cultural change | All persons working in or in collaboration with the criminal justice system should be trained in restorative practices so that they are confident in using these skills, principles and processes in their day-to-day work. This will help support the development of more responsive, relational, participatory, procedurally just and reflective organisational cultures. |

Source: *Restorative justice: strategies for change*, 2019, pp. 5–8

more recently, under the Criminal Justice (Victims of Crime) Act 2017.^{2,3,4} Table 1 presents a summary of key questions that arise regarding restorative justice in Ireland.¹

Strategy background

The idea for the strategy arose from discussions between restorative justice scholars, policymakers, and practitioners attending the 10th International Conference of the European Forum for Restorative Justice (EFRJ) in Tirana, Albania in June 2018.¹ Dr Ian Marder, Gert Jan Slump of Restorative Justice Nederland, and representatives of the EFRJ, Tim Chapman, Dr Bart Claes and Edit Törz, agreed to act as project partners. The agreed purpose for the project was to:

- Contribute towards refocusing European criminal justice systems, agencies, policies, and practices around restorative principles and processes
- Determine how the Council of Europe Recommendation CM/Rec(2018)8 concerning restorative justice in criminal matters could be used to support this work.

To achieve these aims, four core members were appointed in Ireland and nine other participating European jurisdictions: Albania, Belgium, Czechia, Estonia, Italy, the Netherlands, Poland, Portugal and Scotland. Core members in each area mainly come from academia, justice departments, criminal justice agencies, and non-governmental organisations (NGOs). Ireland's core members are Dr Ian Marder (Maynooth University); Ursula Fernée (Restorative Justice and Victim Services Unit, Probation Service); Tim Chapman (Ulster University); and Dr Kieran O'Dwyer (Kennedy Institute Peacebuilding Group). Core members have been in place since January 2019 and the project is expected to last four years.

Strategic pillars

The collective strategy for Ireland is centred on information collected from attendees at the Restorative Justice: Strategies for Change Symposium (n=94) at Maynooth University in March 2019.¹ People and stakeholders who were unable to attend were also given an opportunity to contribute information by email. Three strategic pillars for the strategy were identified and formed the basis of the final report (see Table 2). An outline of the main objectives and potential actions for each pillar is presented in the strategy.¹

Steps to implementation

On 4 June 2019, the authors began the process of disseminating the strategy. They requested that all those on the Stakeholder Group (or who otherwise have an interest in, or responsibility for, the development and use of restorative justice in the Irish CJS) assist them in doing so by publishing the strategy on their organisational websites, mentioning it in their newsletters, and circulating and discussing it widely among colleagues.

They are currently designing the process by which, in collaboration with the Stakeholder Group and with other stakeholders, they will devise and implement specific actions that contribute to achieving the objectives outlined under each strategic pillar. If anyone would like to join the Stakeholder Group, please email Dr Ian Marder (ian.marder@mu.ie) with your name, role and organisation.¹

Ciarra H Guiney

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- 6 O'Dwyer K (2014) *Towards excellence in restorative practice: a quality assurance framework for organisations and practitioners*. Dublin: Restorative Practices Strategic Forum. Available online at https://www.cdi.ie/wp-content/uploads/2016/11/RPSF_QA_Framework_FINAL.pdf

Addressing educational disadvantage – Youthreach and DEIS

Educational disadvantage is widely recognised as a risk factor for substance misuse.¹ Improving supports for young people at risk of early substance use is an action of the national drugs strategy – *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025* (Action 1.2.5),² which identifies the preventative role of programmes that support young people to stay in education. The Government funds several programmes in this area and two of its key programmes have recently been evaluated:

- **Youthreach:** *Evaluation of the National Youthreach Programme*¹
- **Delivering Equality of Opportunity in Schools (DEIS):** *The evaluation of DEIS at post-primary level: closing the achievement and attainment gaps.*³

PROGRAMME 1: Youthreach

Youthreach is the Irish Government's primary response to early school-leaving. It aims 'to provide early school leavers (16–20 years) with the knowledge, skills and confidence required to participate fully in society and progress to further education, training and employment' (p. 9).⁴ It is described as not only having a focus on progression to education and training but also plays a role in facilitating social inclusion (p. xi).¹ The programme has been the subject of an in-depth evaluation, whose findings were published in June 2019 in *Evaluation of the National Youthreach Programme*.¹

Youthreach provides what is described as 'second-chance education' for those who have left mainstream second-level school before Leaving Certificate level (p. xi). It is delivered in two settings that have their own distinct governance and funding structures: Youthreach centres, of which there are 112 nationally; and Community Training Centres, of which there are 35 nationally. Centres vary in what they offer learners. While QQI Levels 3 and 4 are the most common courses offered, some provide Level 2 courses and the Leaving Certificate Applied programme. A small number offer the Junior Certificate and the Leaving Certificate. In 2017, some 11,104 learners took part in the programme (p. xi).

Methods

The evaluation takes a mixed methods approach, combining quantitative and qualitative data gathered from a range of stakeholders. This approach enables the evaluators to assess the programme's effectiveness and reflect the multiple challenges being faced by young people involved with the programme, for example, socioeconomic disadvantage and special educational needs. Furthermore, the approach captures the range of outcomes being achieved by a programme which promotes the development of a broad set of skills among young people, with an emphasis on personal and social development.

The evaluation team carried out surveys of senior managers at Education and Training Board level, centre coordinators

and managers; and in-depth case studies of 10 centres, which involved qualitative interviews with staff, coordinators/managers, and current and former learners. They emphasise the importance of capturing young people's voices through the evaluation; they describe the interviews with young people as having yielded new insights into their pathways into the programme, their experiences of Youthreach, and the impact they feel it has had on them.

Selection of findings

The report is highly detailed and explores all aspects of the programme, including the profile of learners; referral to the programme; governance and reporting structures; programme funding and resources; curriculum; approaches to teaching and learning; and learner experiences and outcomes. It is beyond the scope of this article to provide a detailed description of the full range of findings; however, a selection of key findings is provided here.

Increased marginalisation

While there has been a notable decline in the number of early school-leavers in Ireland since 2009, this group was found to have become 'more marginalised in profile' (p. 205) over time. What is described as a 'striking finding' (p. 205) is that young people are presenting to Youthreach with greater levels of need, with increased prevalence of mental health and emotional problems as well as learning difficulties. Among the challenges faced was substance misuse – both that of young people themselves and that of a family member. This concentration of complex needs was found to have implications for the kind of support required by learners and the staff skill set necessary to meet these needs.

Programme aims and outcome measurements

Senior managers and coordinators adopted a holistic view of the programme aims. While there was some variation between groups of stakeholders, overall they perceived the programme as having multiple aims, including re-engaging young people in learning; providing a positive learning experience; fostering the development of personal and social skills, the acquisition of qualifications, and progression to education, training and employment. Given this broad perspective, they were largely critical of the current system in which the programme's metrics only capture the aims of the programme in terms of progression to education, training, and employment.

Course content and learning

As mentioned above, centres varied in the courses and qualifications they offered. While this was in part attributed to governance structures, the findings overall indicated that centres tailored provision to learner needs. As well as accredited courses provided by Quality and Qualifications Ireland (QQI) and the State Examinations Commission, the vast majority also offered other activities to meet the needs of their learners. Among these were 'courses and talks around drug awareness' (p. 209). Overall, learners were very positive about their Youthreach learning experiences, especially when compared with their experience of mainstream education.

Additional supports

Given the needs profile of Youthreach learners, providers offered a range of other supports for learners. These included work placement, career guidance, personal counselling, and informal support from staff. The evaluation found that central to this was the quality of relationships with staff and other young people. Learners reported that the support, respect, and care they received from centre staff were critical.

Addressing educational disadvantage continued

Outcomes

Evidence on outcomes was reported through the routine monitoring system for Youthreach (SOLAS FARR database), the study surveys, and qualitative interviews. Findings from the quantitative indicators of outcomes included that, for 2017, the SOLAS FARR database indicated non-completion rates of 14% across the programme; for the same year, the accreditation rate for both full and component awards was 42%. When comparing the number of awards with the number of learners (using survey data from coordinators and managers), an estimated 60% of those completing the programme received a full award. Also, according to the survey data, 45% of completers progress on to another education or training course; 43% go straight into the labour market; and one in six completers are unemployed (pp. 211–12).

Positive outcomes related to the development of personal and social skills as well as enhancement of emotional wellbeing were also reported. For example, learners identified improvements in their engagement with learning, increased self-confidence, and the development of 'a purpose in life and hope for the future' (p. 212). As mentioned above, there was heavy criticism of these outcomes not being captured through routine monitoring systems.

Conclusion

Overall, the study findings indicate that the programme works well as second-chance provision for often vulnerable young people with complex needs.

[It offers a] positive experience of teaching and learning, fostering personal and social skill development, and equipping many with certification to access further education, training and employment options providing courses and approaches tailored to their needs, and embedding education/training provision within a broader network of supports. (p. xvii)

PROGRAMME 2: DEIS

Delivering Equality of Opportunity in Schools (DEIS) is the Department of Education and Skills' policy instrument to address educational disadvantage, which was launched in 2005. It aims to improve attendance, participation, and retention in designated schools located in disadvantaged areas. A range of supports is provided to participating schools; for example, a lower pupil-teacher ratio in some schools; access to the Home School Community Liaison Scheme; the School Meals Programme; and literacy and numeracy supports.

The programme has been the subject of a number of reports, the most recent of which is *The evaluation of DEIS at post-primary level: closing the achievement and attainment gaps*, published in late 2018 by the Educational Research Centre.³ The report looks at achievement and retention in DEIS and non-DEIS schools at post-primary level.

Key findings

Overall achievement

Between 2002 and 2016, there was a narrowing of the gap in Junior Certificate examination (JCE) achievement between DEIS and non-DEIS schools, as measured by the overall

performance scale (OPS).⁵ The average annual rate of increase in non-DEIS schools from 2002 to 2016 was 0.19 OPS points, but was significantly higher ($p < 0.001$) for DEIS schools, at an average increase of 0.33 OPS points per year (see Figure 1). What this means in terms of grades (A–E) is that DEIS schools saw an increase over the period that was equivalent to an approximate increase of one letter grade. A similar increase was not found in non-DEIS schools. The overall gap in OPS reduced from 10.5 points in 2002 to 4.6 in 2016. When looking at two specific subjects, a narrowing of the gap was also found for English and mathematics.

Retention

The study found a significant upward trend in both Junior Cycle and Senior Cycle retention for the entry cohorts between 1995 and 2011 across all schools. Those entering 1st Year in 1995 had a Junior Cycle retention rate of 94.3%, which had increased to 97.1% for the 2011 cohort. For the same period, the Senior Cycle retention rate increased from 77.3% to 90.2%. Despite a narrowing of the gap, there continues to be sizeable gaps in retention between DEIS and non-DEIS schools in both cycles. For the 1995 cohort, there was an 8.6 percentage point gap for Junior Cycle, which had reduced to 2.2 percentage points for the 2011 cohort. For Senior Cycle, there was a 22.1 percentage point gap for the 1995 cohort; for the most recent cohort, it was 11 percentage points.

Medical card possession and achievement

In both DEIS and non-DEIS schools, gaps existed between the average achievements of students from medical card-holding families and those from families without medical cards; those without medical cards outperformed those with medical cards.

Social context effect

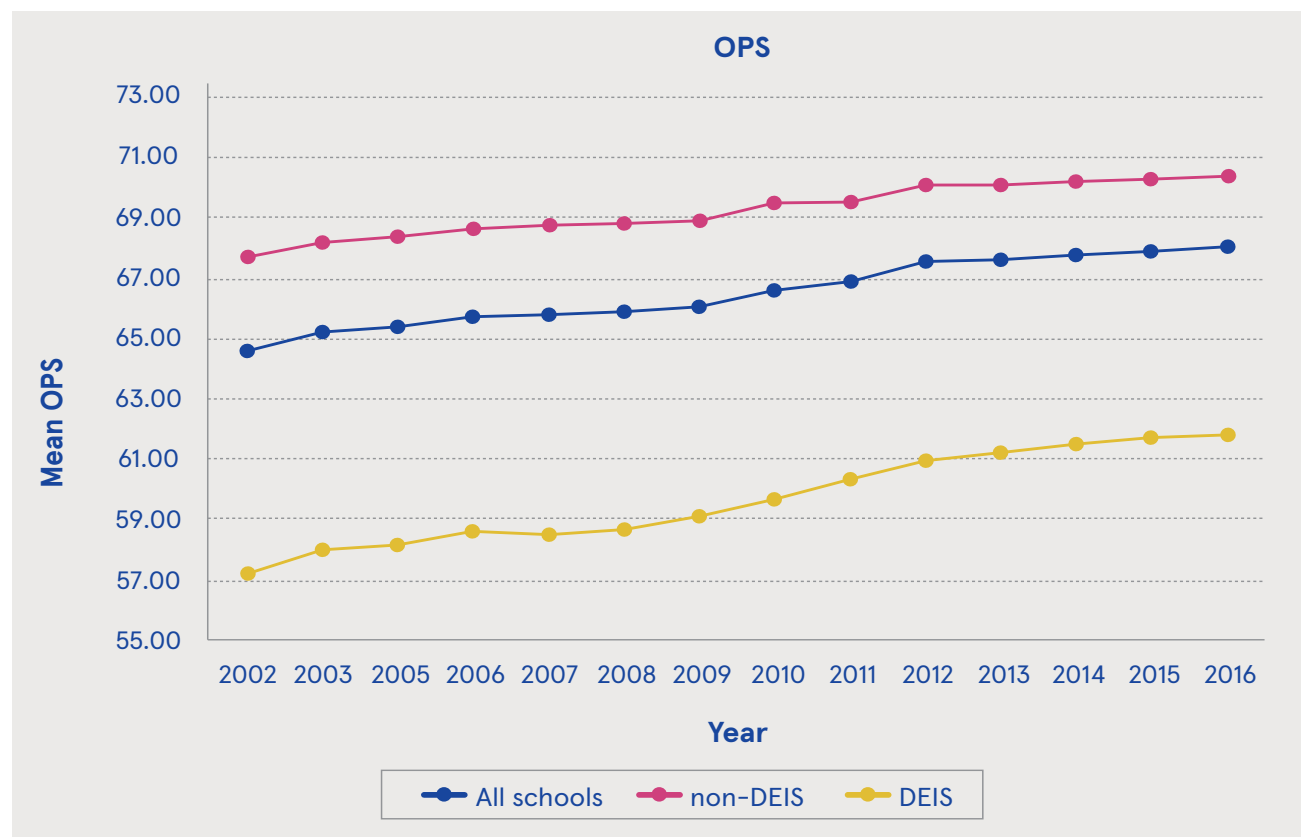
The authors explored whether there was a 'social context effect' on student achievement. They tested the hypothesis that increasing concentrations of students from socioeconomically disadvantaged backgrounds would have a negative impact on individual student achievement, irrespective of that individual's own socioeconomic background. The two student-level variables on which data were available – gender and medical card possession – explained 31% of the between-school variance in English and mathematics achievement in 2016. The addition of the measure of social context, that is, the percentage of students from medical card-holding families in a school, explained an additional 40% of the between-school variance in English achievement and an additional 42% of the between-school variance in mathematics achievement in 2016. This indicates a clear social context effect – the impact of being a student in a school with concentrations of other socioeconomically disadvantaged backgrounds has a substantial negative impact on achievement, regardless of whether a student has a medical card themselves or not.

Final comment

The report is descriptive of changes over time and illustrates a narrowing of the gap between DEIS and non-DEIS schools. As suggested by the authors, the findings on medical cards and the social context effect suggest support for policies that target resources at schools with concentrations of students from socioeconomically deprived backgrounds. However, the report is limited in its inability to conclude whether or not the changes found are attributable to the DEIS programme. As with previous DEIS reports, a key limitation is that a control group is not used; therefore, it cannot be established with any certainty whether improvements are due to the programme or to improvements that would have happened anyway.

Addressing educational disadvantage continued

Figure 1: Average OPS score in the Junior Certificate examination from 2002 to 2016 in all schools, DEIS schools, and non-DEIS schools*



Source: Weir and Kavanagh, 2018, p. 83

* OPS data for 2004 were not available to the authors.

Lucy Dillon

- 1 Smyth E, Banks J, O'Sullivan J, McCoy S, Redmond P and McGuinness S (2019) *Evaluation of the National Youthreach Programme*. Dublin: Economic and Social Research Institute. <https://www.drugsandalcohol.ie/30687/>
- 2 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 3 Weir S and Kavanagh L (2018) *The evaluation of DEIS at post-primary level: closing the achievement and attainment gaps*. Dublin: Educational Research Centre. Available online at: <https://www.education.ie/en/Schools-Colleges/Services/DEIS-Delivering-Equality-of-Opportunity-in-Schools-/the-evaluation-of-deis-at-post-primary-level-closing-the-achievement-and-attainment-gaps.pdf>
- 4 Department of Education and Skills (DES) (2015) *Operator guidelines for the Youthreach programme*. Dublin: DES.
- 5 OPS is a tool in which a numerical value is attached to each of the alphabetical grades (A-E) awarded to JCE candidates for each subject; summing these values produces an index of a candidate's general scholastic achievement across their seven best subjects. These are then aggregated to produce an index of achievement in the JCE at a school level.

Tabor Group annual report, 2018

The Tabor Group is a provider of residential addiction treatment services in Ireland. It aims to offer hope, healing, and recovery to clients suffering from addictions through integrated and caring services. In addition to three residential facilities, the organisation provides a continuing care programme to clients who have completed treatment in order to assist with their recovery. It also offers counselling to families whose loved ones are struggling with an addiction. In 2019, the Tabor Group published its annual report.¹ This article highlights services provided by the Tabor Group to individuals with a substance use addiction in 2018.

Tabor Lodge: residential addiction treatment centre

Tabor Lodge is a residential addiction treatment centre for people addicted to alcohol, drugs, gambling, and food. It is situated 15 miles south of Cork city. Tabor Lodge is guided by the Minnesota Model of addiction treatment in delivering its treatment programme. This model is characterised by the understanding that addiction is primarily a substance use disorder. The primary focus of the treatment programme is to educate clients on the dynamics of this disorder as they manifest in the life of the individual. Another important focus of the treatment programme is to assist clients develop the skills necessary to manage their disorder while going forward in their lives.

A total of 222 clients (72% male) were admitted to Tabor Lodge for residential treatment of addiction in 2018, of whom 208 completed treatment. A breakdown of the specific drug of choice for admissions in 2018 is shown in Table 1. The clinical staff at Tabor Lodge have observed a changing profile of clients presenting for treatment in recent years, with mental health challenges and a history of childhood trauma becoming more evident. With this in mind, staff at Tabor Lodge have become more informed about childhood trauma as a contributing factor to the development of addiction, and as a hindering factor in efforts to manage addiction disorders. In 2017, Tabor Lodge responded to the greater prevalence of clients presenting for treatment with a history of childhood trauma by initiating a training programme. This is to ensure that services

Table 1: Specific drug of choice for clients admitted to Tabor Lodge: residential addiction treatment centre, in 2018

| Drug of choice | Number of clients | Percentage of clients (%) |
|-------------------------|-------------------|---------------------------|
| Opiates | 12 | 5 |
| Cocaine | 29 | 13 |
| Cannabis | 12 | 5 |
| Alcohol | 148 | 67 |
| Stimulants | 1 | 0.5 |
| Hypnotics and sedatives | 10 | 5 |
| Other substances | 2 | 1 |

Source: Tabor Group, 2019

at Tabor Lodge become more 'trauma informed', as an agency treating adults vulnerable to the ongoing debilitating impact of childhood trauma.

Fellowship House: men's residence extended treatment centre

The extended treatment programme for men is based on the Hazelden Minnesota Model and promotes 'total abstinence'. The aim is to build on and consolidate the work of recovery already begun in primary treatment – even if that treatment was not in the recent past and the client is struggling to maintain sobriety.

In 2018, some 34 clients were admitted to Fellowship House for extended treatment; a total of 18 individuals completed the programme. A breakdown of the specific drug of choice for admissions to Fellowship House in 2018 is shown in Table 2. The report observed that cannabis and cocaine remain high at 82%, with 94% of clients reporting alcohol as their specific drug of choice.

Table 2: Specific drug of choice for clients admitted to Fellowship House: men's residence extended treatment centre, in 2018

| Drug of choice | Number of clients | Percentage of clients (%) |
|-----------------------|-------------------|---------------------------|
| Alcohol | 32 | 94 |
| Ecstasy | 25 | 74 |
| Cannabis | 28 | 82 |
| Cocaine | 28 | 82 |
| Prescribed medication | 26 | 76 |
| Heroin | 9 | 26 |
| Methadone | 4 | 12 |
| Speed | 21 | 62 |
| LSD | 18 | 53 |
| Other/Headshop | 10 | 29 |

Source: Tabor Group, 2019

Renewal: women's residence extended treatment centre

Renewal works with women who have completed a primary 28-day treatment programme. It is a 12-week residential extended treatment programme, where clients learn to find routine, balance, and structure. Renewal is the only Minnesota Model extended treatment centre for women based in Ireland and was opened in 1999.

In 2018, some 51 clients were admitted to Renewal, of which 30 completed the programme. Seventy per cent of these clients were aged between 18 and 35 years. A breakdown of the specific drug of choice for admissions to Renewal in 2018 is shown in Table 3. In this year, 90% of clients admitted presented with a history of alcohol abuse.

In addition to group therapy, lectures and one-to-one counselling, the programme at Renewal also arranges family conferences, which help clients to reconnect with their families as well as educating families about addiction and offering them support. The programme also works in partnership with Tusla, the Child and Family Agency, as many women have children in care and need help reconnecting and rebuilding the parent/child relationship.

Tabor Group annual report, 2018

continued

Table 3: Specific drug of choice for clients admitted to Renewal: women's residence extended treatment centre, in 2018

| Drug of choice | Number of clients | Percentage of clients (%) |
|-----------------------|-------------------|---------------------------|
| Alcohol | 46 | 90 |
| Ecstasy | 33 | 65 |
| Cannabis | 35 | 69 |
| Cocaine | 35 | 69 |
| Prescribed medication | 37 | 73 |
| Heroin | 13 | 25 |
| Methadone | 9 | 18 |
| Speed | 26 | 51 |
| LSD | 15 | 29 |
| Other/Headshop | 4 | 8 |

Source: Tabor Group, 2019

Conclusions

The Tabor Group observed that the number of people presenting with opiate or heroin addiction was down from 8% in 2017 to 5% of all presentations in 2018. However, cocaine use among all clients presenting for treatment has more than trebled since 2016 – up from 4% to 13% – with cannabis also up 1% in the past year. In addition, addiction to alcohol alone is seen rarely, according to the report, with large numbers of people presenting for treatment indicating polydrug use, with ecstasy, cannabis, cocaine, heroin, and prescribed medication being reported.

Seán Millar

¹ Tabor Group (2019) *Tabor Group annual report 2018*. Cork: Tabor Group. <https://www.drugsandalcohol.ie/30698/>



National Drugs Library

UPDATES

Recent publications

PREVALENCE AND CURRENT SITUATION

Mapping service user needs to inform a supervised injecting room location in Cork, Ireland

Horan JA and Van Hout MC (2019) *Heroin Addiction and Related Clinical Problems*, Early online.
<https://www.drugsandalcohol.ie/30540/>

The aim of the study was to map the location of current injecting practices of people who inject drugs (PWID) in Cork, Ireland, and to document the related high-risk behaviours, ahead of a planned supervised injecting facility [SIF].

The study provides an understanding of PWID profile and risk behaviours, alongside a geospatial analysis of injecting, overdose and potential location of a SIF in Cork, Ireland. The findings are intended to inform SIF location, and would allow dynamic comparison of both geographic and behavioural changes injecting drug use over time, post SIF provision.

Making sense of street chaos: an ethnographic exploration of homeless people's health service utilization

O'Carroll A and Wainwright D (2019) *International Journal for Equity in Health*, 18(113).
<https://www.drugsandalcohol.ie/30847/>

Homeless people have poor health and mortality indices. Despite this they make poor usage of health services. This study sought to understand why they use health services differently from the domiciled population.

An explanatory critical realist model integrating the identified generative mechanisms, external and internalised barriers was developed to explain why the health service utilization of homeless people differs from the domiciled populations. This new model has implications for health service policy makers and providers in how they design and deliver accessible health services to homeless people

Longitudinal social network analysis of peer, family, and school contextual influences on adolescent drinking frequency

McCann M, Jordan J-A, Higgins K and Moore L (2019) *Journal of Adolescent Health*, 65(3): 350–358.
<https://www.drugsandalcohol.ie/30795/>

The aim of the study was to identify the mechanisms relating to parental control, adolescent secrecy, and school context that shape patterns of adolescent drinking frequency and appraise the implications for systems-level intervention.

Our results suggest that the optimal strategy for selecting seed nodes in a diffusion of innovations network intervention may vary according to school context, and that targeting family interventions around parent characteristics may modify the wider school network, potentially augmenting network intervention processes.

A psychoactive paradox of masculinities: cohesive and competitive relations between drug taking Irish men

Darcy C (2019) *Gender, Place & Culture*, Early online.
<https://www.drugsandalcohol.ie/30766/>

This article explores one dimension of Ireland's illicit drug landscape: men's predominance as recreational users of illicit psychoactive substances. It uses a gender lens on Irish men's drug taking practices, to reveal how men's drug use and drug intoxication converge with masculinities in paradoxical ways.

By employing a masculinities lens to analyse men's recreational use of illicit psychoactive substances, men's drug taking interactions reveal intricacies within the gender order. I argue that illicit drugs are resources that some men utilise to navigate conventional understandings of masculinity, albeit in paradoxical ways.

Cognitive performance and mood after a normal night of drinking: a naturalistic alcohol hangover study in a non-student sample

Devenney LE, Coyle KB and Verster JC (2019) *Addictive Behaviors Reports*, 10 (100197).
<https://www.drugsandalcohol.ie/30756/>

The aim of this study was to investigate the effects of a normal night of alcohol consumption on next-day cognitive performance in a non-student sample.

The current study in a non-student sample confirms previous findings in student samples that cognitive functioning and mood are significantly impaired during alcohol hangover.

Recent publications continued

Limiting psychotropic medication prescription on discharge from psychiatric inpatient care: a possible suicide intervention?

Cleary E, Kelleher CC, Lane A and Malone K (2019) *Irish Journal of Psychological Medicine*, Early online.

<https://www.drugsandalcohol.ie/30659/>

This study aimed to assess the quantity, toxicity and potential lethality of psychotropic medication being prescribed on discharge from psychiatric care to those with and without indices of suicidality.

Patient discharge from inpatient psychiatric care presents a golden opportunity to moderate access to potentially fatal psychotropic medication. Iatrogenic provision of lethal means for suicide during a period of increased risk and in a group at increased suicide risk may impact suicide prevention efforts and requires further in-depth research. Current prescribing practices may be a missed opportunity to intervene in this regard.

Sleep after heavy alcohol consumption and physical activity levels during alcohol hangover

Devenney LE, Coyle KB, Roth T and Verster JC (2019) *Journal of Clinical Medicine*, 8(5): 752.

<https://www.drugsandalcohol.ie/30603/>

The current study examined the impact of an evening of alcohol consumption on sleep, and next day activity levels and alcohol hangover.

The outcome of this study underlines that, in addition to retrospectively reported data, real-time objective assessments are needed to fully understand the effects of heavy drinking.

Fetal growth and maternal alcohol consumption during early pregnancy

Reynolds CME, Egan B, O'Malley EG, McMahon L, Sheehan SR and Turner MJ (2019) *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, 236: 148–153.

<https://www.drugsandalcohol.ie/30588/>

The relationship between light maternal alcohol consumption and fetal outcome remains contentious and the professional advice women receive is conflicting. The aim of this large epidemiological study was to examine the relationship between fetal growth and maternal alcohol behaviour before and during early pregnancy.

Women who consume alcohol should continue to be advised of the fetal and maternal risks of heavy consumption and, if applicable, of the need to quit smoking and avoid illicit drugs. However, women who have consumed alcohol before realising that they were pregnant, or who consumed alcohol in light amounts during early pregnancy, may be reassured that their alcohol consumption did not impact adversely on their baby's growth.

Dietary intakes of smokers compared to non-smokers at the first prenatal visit

O'Malley EG, Cawley S, Kennedy RAK, Reynolds C, Molloy and Turner MJ (2019) *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, 234: e159.

<https://www.drugsandalcohol.ie/30587/>

In this prospective study, we compared the dietary intakes of micronutrients and macronutrients at the first prenatal visit of women who reported continuing to smoke during pregnancy with the intakes of women who were non-smokers.

We found that women who continue to smoke during pregnancy have serious dietary inadequacies which potentially may aggravate fetal growth restriction. This provides a further reason to promote smoking cessation interventions in pregnancy and highlights the need for dietary and supplementation interventions in women who continue to smoke.

The role of sex and age on pre-drinking: an exploratory international comparison of 27 countries

Ferris J, Puljević C, Labhart F, Winstock A and Kuntsche E (2019) *Alcohol and Alcoholism*, 54(4): 378–385.

<https://www.drugsandalcohol.ie/30519/>

This exploratory study aims to model the impact of sex and age on the percentage of pre-drinking in 27 countries, presenting a single model of pre-drinking behaviour for all countries and then comparing the role of sex and age on pre-drinking behaviour between countries.

Pre-drinking is a worldwide phenomenon, but varies substantially by sex and age between countries. These variations suggest that policy-makers would benefit from increased understanding of the particularities of pre-drinking in their own country to efficiently target harmful pre-drinking behaviours.

Global alcohol exposure between 1990 and 2017 and forecasts until 2030: a modelling study

Manthey J, Shield KD, Rylett M, Hasan OSM, Probst C and Rehm J (2019) *Lancet*, 393 (10190): 2493–2502.

<https://www.drugsandalcohol.ie/30508/>

Alcohol use is a leading risk factor for global disease burden, and data on alcohol exposure are crucial to evaluate progress in achieving global non-communicable disease goals. We present estimates on the main indicators of alcohol exposure for 189 countries from 1990–2017, with forecasts up to 2030.

Based on these data, global goals for reducing the harmful use of alcohol are unlikely to be achieved, and known effective and cost-effective policy measures should be implemented to reduce alcohol exposure.

Recent publications continued

Comparison of the health and wellbeing of smoking and non-smoking school-aged children in Ireland

Evans DS, O'Farrell A, Sheridan A and Kavanagh P (2019) *Child: Care, Health and Development*, 45(5): 694–701.
<https://www.drugsandalcohol.ie/30503/>

The study aimed to determine the association between smoking and health and wellbeing indicators among Irish school-aged children.

The findings can be utilised to counteract positive perceptions of smoking among schoolchildren. This, combined with providing supports to help children quit may help achieve government targets to reduce smoking prevalence.

POLICY

Women as vulnerable subjects: a gendered reading of the English and Irish drug strategies

Wincup E (2019) *Addictive Behaviors*, 98: 105995.
<https://www.drugsandalcohol.ie/30789/>

Highlights

- Both strategies use vulnerability to understand women's pathways into/out of drugs.
- The UK strategy concentrates on 'victimized' women who are vulnerable to drug use.
- The Irish strategy focuses on women's continuing drug use due to poor service provision.
- Both strategies fall short of a gender-responsive approach to drug policy.
- Gender mainstreaming is needed to develop more inclusive drug policies.

Brexit threatens the UK's ability to tackle illicit drugs and organised crime: What needs to happen now?

Roman-Urrestarazu A, Yang J, Robertson R, McCallum A, Gray C, McKee M and Middleton J (2019) *Health Policy*, 123(6): 521–525.
<https://www.drugsandalcohol.ie/30580/>

The decision by the UK government to leave the European Union comes at a time when parts of the UK are experiencing a marked rise in reported gun and knife crimes. The health effects of Brexit will have serious consequences as to how the UK tackles this upsurge in drug-related crime.

The scale of collaboration between the UK and European institutions is extensive. It is not clear how this might be replicated after Brexit. Yet an alternative framework of collaboration between the UK and the EU is clearly needed to facilitate shared and agreed approaches to data sharing and drug surveillance after Brexit.

RESPONSES

Evaluating peer-supported screening as a hepatitis C case-finding model in prisoners

Crowley D, Murtagh R, Cullen W, Keevans M, Laird E, McHugh T, et al. (2019) *Harm Reduction Journal*, 16(1): 42.
<https://www.drugsandalcohol.ie/30754/>

This study's primary aim is to evaluate peer-supported screening as a model of active HCV [hepatitis C virus] case finding with a secondary aim to describe the HCV cascade among those infected including linkage to care and treatment outcomes.

Peer-supported screening is an effective active HCV case-finding model to find and link prisoners with untreated active HCV infection to HCV care.

Recovery in homelessness: the influence of choice and mastery on physical health, psychiatric symptoms, alcohol and drug use, and community integration

Manning RM and Greenwood RM (2019) *Psychiatric Rehabilitation Journal*, 42(2): 147–157.
<https://www.drugsandalcohol.ie/30634/>

The purpose of this study was to test the hypothesis that choice in housing and services would predict recovery in a number of domains, and that these relationships would be mediated by mastery.

Findings add further support to the growing body of evidence that suggests choice is centrally important to recovery experiences among individuals in homelessness.

Smoking cessation interventions

Lowry-Lehnen T (2019) *Update Respiratory Medicine*, 5(5): 35–38.
<https://www.drugsandalcohol.ie/30569/>

The number of smokers in Ireland has decreased by an estimated 80,000 people over the past three years. The prevalence of smoking dropped from 23 per cent in 2015 to 20 per cent in 2018. So about 20 per cent of the population are current smokers; 17 per cent are daily smokers, down from 19 per cent in 2017, and 44 per cent of all smokers have made an attempt to quit in the past 12 months (Healthy Ireland 2018). While much progress has been made, tobacco use is still the leading cause of preventable death in Ireland with almost 6,000 smokers dying each year from tobacco-related diseases.